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**POSSIBLE IRREGULARITIES IN MEDICAL EXAMINA-
TIONS PURCHASED FROM "VOLUME PROVIDERS"
FOR THE SOCIAL SECURITY DISABILITY PROGRAM**

HEARING
BEFORE THE
SUBCOMMITTEE ON SOCIAL SECURITY
AND THE
SUBCOMMITTEE ON OVERSIGHT
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
NINETY-SEVENTH CONGRESS
SECOND SESSION

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MARCH 11, 1982
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Serial 97-55
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POSSIBLE IRREGULARITIES IN MEDICAL EXAMINATIONS PURCHASED FROM "VOLUME PROVIDERS" FOR THE SOCIAL SECURITY DISABILITY PROGRAM

THURSDAY, MARCH 11, 1982

HOUSE OF REPRESENTATIVES, COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON SOCIAL SECURITY, SUBCOMMITTEE ON OVERSIGHT,

Washington, D.C.

The subcommittees met at 10:05 a.m., pursuant to notice, in room 1100 Longworth House Office Building, Hon. J. J. Pickle (chairman of the Subcommittee on Social Security) and Hon. Charles B. Rangel (chairman of the Subcommittee on Oversight) presiding.

[The press release announcing the hearing follows:]

[Press release of Thursday, Feb. 25, 1982]

HON. J. J. PICKLE AND HON. CHARLES B. RANGEL, CHAIRMEN OF THE WAYS AND MEANS SUBCOMMITTEES ON SOCIAL SECURITY AND OVERSIGHT, RESPECTIVELY, ANNOUNCE JOINT HEARINGS ON POSSIBLE IRREGULARITIES IN MEDICAL EXAMINATIONS PURCHASED FROM "VOLUME PROVIDERS" FOR THE SOCIAL SECURITY DISABILITY PROGRAM

The Honorable J. J. Pickle, (D-Texas), Chairman of the Subcommittee on Social Security, and the Honorable Charles B. Rangel, (D-N.Y.), Chairman of the Subcommittee on Oversight, Committee on Ways and Means, announced today that their Subcommittees would hold a joint hearing on the procedures which cover the purchase of independent medical exams. These hearings will be held on Thursday, March 11, 1982, at 10:00 a.m. in Room 1100, Longworth House Office Building. Medical examinations play a crucial role in determining an individual's eligibility for social security and SSI disability benefits and their quality and timeliness go to the heart of both the fairness and the solvency of the programs.

In their earlier hearing, held September 18, 1981, the Subcommittees heard from officials of the Social Security Administration, and directors of the Pennsylvania and Tennessee agencies, who make disability determinations, to assess the nature of the problem of "volume providers" and to ascertain the role and responsibility of Federal and State governments, respectively, in supervising these providers of medical examinations. At that time, it was stated that the individuals who have questioned the operation of "volume providers" would be given an opportunity to testify before the Subcommittees. These individuals and other persons interested in this problem area will be heard on March 11, 1982.

Individuals and organizations interested in presenting oral testimony at the hearing should submit their request to be heard by telephone, to be followed by a formal written request, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515, telephone (202) 225-3627. The initial telephone request must be received by the Committee not later than the close of business, March 5, 1982. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

It is urged that persons and organizations having a common position make every effort to designate one spokesman to represent them in order for the Subcommittee

to hear as many points of view as possible. Time for oral presentation will be strictly limited, with the understanding that a more detailed statement can be submitted for the Subcommittee's review and for inclusion in the printed record of the hearings. This will afford more time for interrogation of the witnesses by the members of the Subcommittee. If it becomes necessary, the staff will group the witnesses into panels to expedite the hearings and will establish strict time limitations for each panelist.

The following is an outline of the procedure to be followed by organizations and individuals who may either want to appear and testify during this hearing or file a written statement for the printed record of the proceedings. All requests to be heard should contain the following information:

1. The name of the witness, his title, address, firm affiliation and/or organization he will represent (as well as a telephone number where he or his designated representative may be reached).

If appearing in an individual capacity, a list of any clients at whose requests or in whose employ the witness appears.

3. A topical outline or summary of comments and recommendations.

The above information should also be incorporated in the prepared statements to be presented in person as well as those filed for the printed record. In order to assure the most productive use of the limited amount of time available to question hearing witnesses, witnesses scheduled to appear before the Subcommittee are required to submit 50 copies of their prepared statement to the full Committee office, Rm. 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person. For those who wish to file a written statement for the record of the hearing, five copies are required and may be submitted through the close of business, March 19, 1982, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office before the hearing begins.

Chairman PICKLE. The subcommittees will come to order.

I have a statement which I wish to read first to refocus on some of the review and the difficulties we are experiencing in this area of volume providers. Since I want it to be made a part of the record, I am going to proceed to make the statement.

Chairman Rangel is on his way to the subcommittee now, and we will be proceeding in this manner. So I will now submit our statement.

Over the past several years of study conducted by the Ways and Means Committee of the Social Security disability program, we have come to the same conclusion repeatedly—namely, that adequate medical evidence plays a central role in making the program an equitable one and in keeping the administration of the program under control. The definition of disability in the Social Security Act rests heavily upon the medical determination.

Section 223 of the Social Security Act reads, "The term 'disability' means inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairments." I want to emphasize that again, any medically determinable physical or mental impairment.

Again, the same section says, "Physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical laboratory diagnostic techniques."

Now that sure is a gobbledygook way of saying that. Let us speak to the lawmakers about that. [Laughter.]

There is nothing more important than getting direct, adequate, and timely medical evidence to the State agency who must make

the initial determination of eligibility for disability or for continuation of disability benefits. Getting good medical evidence in a timely manner has not been an easy task.

We must find doctors experienced in disability examination who will provide information in a format usable to the State agency. We must see that they are paid a reasonable fee and that they are paid for their work in a timely manner. ♡

The last Congress, in the legislation which is now Public Law 95-265, included a provision to pay for the reproduction of existing medical evidence to try and help this process along. Today we are looking for a second time at another step in the process, the consultative medical examination. A consultative exam, or CE as it is called, comes into play when the evidence brought in by the claimant is not sufficient to make a determination of disability, or when the agency is reviewing a beneficiary and needs updated medical evidence.

In these cases, the agency asks the individual to go to a doctor selected by the agency for an examination. The various State agencies currently control the fee schedules for these examinations. They choose or recruit the doctors involved and pay the doctor for his services.

In the push to get medical evidence in a timely manner and in a form usable for State agencies, volume medical providers have arisen. These operations may be housed within one State or operate on an interstate basis. In these operations, a doctor or doctors and support staff have confined their practice exclusively or nearly exclusively to disability examinations, providing an income based on volume and specialization.

The committee has the following concerns about these operations:

No. 1: We do not know much about volume providers. We do not know much about who they are and where they are working. We particularly do not know much about those who operate on an interstate basis, since the States have handled this area separately, and the Social Security Administration seems just now to be getting into this area, at our request.

No. 2: There is an unanswered question of accountability. There seems to be no one in charge of making sure that the volume provider operations, particularly those on an interstate basis, are being run in accordance with SSA standards, whatever they may be—that is, whatever standards there might be—and the quality of standards of the medical profession.

No. 3: Charges have been laid out that in some of these volume provider operations the medical evidence may not be of good quality because the examination is broken down into segments for speed and the medical personnel involved cannot get a good overview of the case.

No. 4: Charges have been made that in a volume provider setup there are insufficient controls over the quality and quantity of laboratory tests.

No. 5: We are concerned that fees in some instances may be held so low that a volume examination business is the only way doctors can engage in disability examinations, forcing the States to use these setups whether they want to or not.

No. 6: The medical profession does not seem to have sufficient physicians who are willing to conduct these examinations individually under the current procedures.

Let me emphasize from the start, however, that this committee is not out to harass the volume provider operation unless or until we have evidence that it is for some reason inherently harmful to the Social Security program. Volume examinations may, with proper controls and accountability, be a viable alternative for providing State agencies with the adequate and timely medical information that they need.

This is a factfinding hearing. Our goal must be to find the best way to get good medical evidence to the State agencies.

Our first witness this morning was scheduled to have been a doctor from Minnesota, but he is being delayed because of the flying conditions. So our first witness this morning will be Mr. Michael L. Glancy, who is cochairman of a Social Security SSI task force, representing the Legal Services of North Carolina.

I presume you represent the Legal Services of Lower Cape Fear, Wilmington, N.C.?

Mr. GLANCY. Yes.

Chairman PICKLE. I also understand, Mr. Glancy, that you are a friend of Congressman Charles Rose.

Mr. GLANCY. Yes, sir, I am.

Chairman PICKLE. So you come well recommended.

Mr. GLANCY. Thank you.

Chairman PICKLE. You have friends in the court to begin with. Whether you hold them depends upon your testimony. [Laughter.]

We are pleased to have you, and we would like for you to go ahead and submit your statement.

STATEMENT OF MICHAEL L. GLANCY, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES; SOCIAL SECURITY-SSI TASK FORCE, LEGAL SERVICES OF NORTH CAROLINA; PARALEGAL, LEGAL SERVICES OF THE LOWER CAPE FEAR, WILMINGTON, N.C.

Mr. GLANCY. Thank you very much, Mr. Chairman. I am pleased to be here for my first time to testify before Congress and am honored that I am asked to testify before you today.

Chairman PICKLE. Mr. Glancy, if you would suspend for just a moment, this is a hearing conducted jointly by the Social Security Subcommittee and the Oversight Subcommittee. Mr. Rangel is very interested in this subject and was delayed because of some people from his district in his office. He has arrived.

So, before we get underway, I have just finished making my statement, Chairman Rangel, which you may or may not have been privileged to edify yourself about, but I would like to ask if you have any comments you would like to make about the hearing at this point.

Mr. RANGEL. Thank you, Mr. Chairman.

I would like to join with you, as you indicated, that the problem created by volume providers for the disability program and for the disability applicants is a very serious one. On the one hand, these providers have been receiving enormous sums of money for consul-

tative exams whose reliability and accuracy are questionable. On the other hand, it appears that many of the applicants are being denied their right to fair, responsible treatment of their claims for disability.

I do hope that as a result of the leadership that you have provided in this area in trying to shine some light on it, that the Congress, and especially our joint subcommittees, might be able to give some legislative direction if it is necessary. Thank you for this opportunity.

Chairman PICKLE. Mr. Rangel, I think the most important thing we do at this stage is to get a lot more information on the record, and find out more about these volume providers, how they operate, who they are, both on an interstate and an intrastate basis. That is really the purpose of the hearing. So, I thank you very much, and I know we will be having additional hearings, perhaps with your committee.

Mr. Glancy, I recognize you again. I thank you for permitting this interruption. You have a statement here which is somewhat lengthy. I wonder if you could sort of summarize the statement and get down to your recommendations. We have some seven or eight witnesses, and we want to hear them and finish this morning. So, if that is agreeable, please proceed.

Mr. GLANCY. That is certainly agreeable with me. I did not intend to read the statement, but I would ask with your permission that it be entered into the record.

Chairman PICKLE. The entire statement will be made a part of the record. You may proceed.

Mr. GLANCY. Thank you, Chairman Pickle and Chairman Rangel. I am honored to be here today. I thank you very much for conducting these hearings to investigate what Chairman Pickle has pointed out rightly is a very crucial and vital aspect of the Social Security disability process—the consultative examination process now utilized by the disability agencies in all 50 States.

My purpose in appearing before you is to point out some of the inadequacies that I have found through careful study and working with the claimants.

Before I get into that, let me tell you a little bit about myself, who I am and why I have come to be here today. My name is Michael Glancy. I am a paralegal with Legal Services of Lower Cape Fear in Wilmington, N.C. where I have worked for the past 6 years as a representative of social security disability claimants.

For the past 2 years, I have worked closely with the private bar in our eight-county area training them in social security law and practices, and have produced a training manual as part of that work. It is being used in all parts of North Carolina to train lawyers in this field, and also in Pennsylvania, Alabama, Michigan, and other States. I am a member of and have been a member of the executive board of the National Organization of Social Security Claimants Representatives, and I am now the cochairman of the Social Security-SSI Committee of the Legal Services of North Carolina.

Just to give you a tiny bit of background of how I got into the consultative examination analysis, our legal services office expand-

ed to take on seven additional counties. We now serve an area the size of Rhode Island and Connecticut.

We found, in handling a number of cases from rural portions of North Carolina, that certain physicians were being sent disability claimants on a routine basis. And in studying these reports, we found quite a number of inadequacies in their reports. We also found inadequacies in the manner in which they conduct these examinations; that is, how they treat the claimant. Often, they treat the claimants in a rude and even hostile manner. We found that they were not conducting the proper diagnostic procedures. We found they were not interpreting the studies that they had ordered as part of the examination and not even bothering to analyze or interpret the clinical abnormalities they found in the course of their own examination.

Therefore, you got reports that often were based on what at times appeared to be fabricated information, or they were based on inadequate studies, or there was no way of interpreting how severe this person's problem is because they just threw out a bunch of information without analyzing it and without interpreting it.

So, what I have concluded in my study is that part of the problem goes back to the monitoring procedures utilized by the State disability determination section. The monitoring procedures are grossly inadequate. Therefore, the system is very susceptible to abuse and is, in fact, abused.

We have doctors who are conducting these examinations and on the average taking from 10 to 15 minutes to provide what is supposed to be a detailed comprehensive examination of a person, and from that 10- or 15-minute examination they write reports that all too often make it appear that the claimant has no physical problem whatsoever. And therefore many—70 to 80 percent—of the people who apply for disability in North Carolina are denied.

Many of the people who are now being reviewed under the continuing disability investigation program are being terminated largely on the basis of these consultative examination reports.

Now, you might ask how do I know the doctors are not performing the diagnostic procedures and interpreting the studies that they do? I am not a doctor. What I have done, and what my first recommendation is which you will find in my written statement I have just summarized the five recommendations on page 7 of my statement.

The five recommendations I have to make today for improving the monitoring and quality assurance program for consultative evaluations utilizing the quality assurance program used in the State disability determination section. The first one is something I have done, and the reason I know the doctors are not performing the examinations or conducting the proper diagnostic procedures.

What I have done as a common practice is take the reports of these consulting physicians and send them to the claimant's treating physician for comment. More likely than not, I would say that the physician responded by saying, I can understand why my patient has been denied disability benefits, because, on the basis of this report, the doctor did not conduct the proper diagnostic studies, did not conduct the proper laboratory studies, and did not per-

form other tests, and order other tests that are quite necessary to the accurate diagnosis of this person's condition.

Or the doctor, the treating physician, will say, well, I know for a fact that this person has this condition. If you perform this study, you will find that condition exists. The implication there being that the doctor, the consulting physician, did not perform the examination, although often they will indicate in their reports that the proper diagnostic procedures were conducted.

I will give you an example of that. I had a woman, a 32-year-old woman had been on disability for some time because she had sickle-cell disease and chronic asthma. Now, sickle-cell disease is a devastating disease. In this case, it was resulting in the complete wasting of her right shoulder and the destruction of the bone in both knees.

She had been operated on one time, one knee had been operated on, and was under the care of an orthopedic surgeon. She was on steroids for 16 years because the asthma condition was so chronic and acute.

This lady was sent to one of the consulting physicians under contract with Social Security, the report was sent to Social Security, and there was no indication that this lady had any kind of asthma problem, no indication that she had any limitation of the range of motion in her shoulder and knees. In short, there was no indication that this woman had any sort of problem that would disable her.

As a consequence, this lady was thrown off the disability rolls, and 2 months ago she died of an asthmatic attack that resulted in severe cardiac arrest.

So, what I did, before she died, actually, I sent the report of the consulting physician to her orthopedic surgeon, who was quite incensed. He noted that anyone with the rotting, decaying shoulder she had was in chronic pain, as she had severe limitations of motion. He could document that and did document that.

He also noted that 1 month prior to the examination by this consulting physician, he himself had operated on her left knee, and he knew for a fact she remained in chronic pain with that condition. And there was marked limitation of motion in that left knee.

So, he made it clear that this consulting physician could not have conducted the range-of-motion studies necessary to accurately diagnose this one condition.

And her allergist, the physician who was treating her for her asthma, made it clear that this woman had to have a breathing machine just to breathe. She had a breathing machine in her home at all times, had a chronic wheeze and a number of pulmonary manifestations.

So, this alarmed me a great deal. This happened about a year ago, and it really triggered my analysis of the consulting evaluation process. Since that time I have begun to study the other consulting physicians and their reports and their processes, and found that this is a recurring pattern, this 10-minute exam, failure to do the diagnostic procedures, inadequate reports that do not interpret the findings, or failure to order the proper tests.

So, that is my first recommendation, that a practice be made that the consulting physician's report be sent to the treating physician where there is a treating physician. This is, I think, an inex-

pensive yet comprehensive way to monitor the performance of the consulting physician.

That is my No. 1 recommendation on page 7. I found that quite effective. The State disability people could see right away if the physician conducted the tests, and the diagnostic procedures.

This would also engage a private physician in a way he has not been engaged before. You would call his competence into question at that point, and he or she would have the opportunity to offer clinical findings that rebut the findings of the consulting physicians.

I have found this a quite effective monitoring procedure and one that I think could be utilized fairly cheaply by the State disability determination sections.

The other recommendations I have to make are rather simple, too. The other flaw in the system is the consulting physician is often never given any background material on the claimant. The claimants are sent in cold with no medical history, no documentation whatsoever of the history of treatment.

I would recommend that that be a standard practice mandated by the Congress that the disability determination sections be required to send all available medical documentation they have on the claimant to the consulting physician prior to the examination so that the consulting physician will begin to get a handle on who this person is, what type of treatment they have had, and if they need to, they can even call the treating physician and say, Doctor, I am seeing your patient, is there anything else I should know about them.

By engaging the treating physician that way, they can come up with a more comprehensive background and analysis of this particular claimant, having some focus for their examination.

Right now, as I see it, these examinations, not only are they brief, but they are so inadequate in many ways. I have derived this information from questioning a number of claimants, asking them what happens in this 9- or 10- or 12-minute examination. Often it is just a routine poke and probe and get off the table and you are out.

And on the basis of this brief encounter, with no medical history to proceed it, these doctors send reports in that often make it appear that this person is in the pink of health. And it is not true at all, as I pointed out in my example.

Another example of that is a 61-year-old woman who has been on SSI disability for some time. She is crippled as a result of traumatic arthritis that came about after she had an accident involving her knee. Her knee is chronically swollen; she needs crutches to walk.

She went to this physician, the same physician, got one of these quickie 10-minute exams, and there is no indication that she had any problem with her knee.

I asked the lady if the doctor had done the routine straight-leg-raising test and range-of-motion study to accurately determine whether the disabling condition exists and how severe that condition is.

She said, "no, the doctor did not even have a stethoscope, hardly touched me. She put her hands on me one time and that was not my knee." But the report of this physician said there is nothing wrong with this woman's knee.

I sent that same woman to her treating physician who did the range-of-motion study and said this woman has gross deformity of the knee, gross limitations of motion. I do not know how a competent physician could have missed that.

These are just two representative samples of what happens when you get some comparison.

What we have done, too, is we have set up our own consulting panel. We have taken money from our limited litigation fund. We have taken claimants who have been seen by one of these consulting physicians and sent them to another doctor and said, Doctor, you do an examination, a regular examination that you do in the course of a routine day.

We find, one, that most doctors will tell you that you cannot do a good examination in under 45 minutes. Often, when we send this same claimant to one of these doctors, we will find you could not tell it was the same person, looking at the consulting physician report and looking at the report by the physician we engaged.

So, by these checks and balances we have employed, this is how I know that these inadequacies exist and why I am making the statement today to you with regard to the consulting evaluation process.

The other thing that concerns me a great deal—I will not go on any further after saying this—is that these consulting physicians often treat these people in a very undignified way, in almost a hostile way.

I found people like this woman, another woman of mine who had a similar knee problem. They were forced to have movements that caused extreme pain, yet the consulting physician would not report that this person was in extreme pain when forcing them beyond the range of motion they could tolerate.

The consulting physician would treat them in a brusque and overtly hostile manner. I think the claimants deserve to know that they can complain, and now they do not know that. The people from State Disability Determination sections will say, well, they know that we referred them there, and they can get back to us, but it is not clear. We are talking about people, many of whom have second-grade educations who have difficulty comprehending the simplest things.

I think you have to point out—this is my final recommendation to you—that it be pointed out in the notice of referral to consulting physician, that you have a right to be treated in a dignified manner and if you are not treated in a dignified manner you can call or write this person whose name appears here and complain or you can complain that this examination was so brief that you do not see how a decent report could be generated from this examination.

That, in essence, is what I have to suggest today, the basis for my complaints about the consulting examination process. I will note that my complaints are focused on the general physicians. We find that the specialists, like the orthopedists, psychiatrists, what have you, do a competent job, in my area, at least.

But the general physical examinations are grossly inadequate, and it is because the system does not have good monitoring procedures to guarantee or ensure quality assurance of the examinations

and reports generated by these physicians. And we have abuses, at least in the general physical examination process.

I thank you very much again for inviting me, and I will be glad to answer any questions you gentlemen have.

[The prepared statement follows:]

STATEMENT OF MICHAEL GLANCY, PARALEGAL, LEGAL SERVICES OF THE LOWER CAPE FEAR, WILMINGTON, N.C.

INTRODUCTION

Mr. Chairman Pickle and Mr. Chairman Rangel, my name is Michael Glancy, I am a Paralegal with Legal Services of the Lower Cape Fear in Wilmington, North Carolina, where I have worked as a representative of Social Security claimants for the past six years. For the past two years, I have worked as a consultant to the private bar in our eight-county service area and in three other areas of North Carolina, training attorneys in Social Security practice and procedures. In conjunction with my work with the private bar, I have produced a Manual on Social Security law and Social Security Practice. This manual has been used in North Carolina as well as in Pennsylvania and other states. I am a past member of the Executive Board of the National Organization of Social Security Claimants Representatives (NOSSCR) and have devoted a good deal of my time to the study of the process by which Social Security handles disability claims.

Over the past year I have devoted an increasing amount of time to the analysis and study of the consultative examination process. This analysis came about as a result of many complaints voiced to me by clients who were seen by a particular physician under contract with the Social Security Administration to perform consultative examinations. As a result of my investigation, I have instituted a Freedom of Information Act request of the Social Security Administration in an effort to obtain more information on the consultative examination process and in particular the monitoring procedures used by the Social Security Administration in policing the conduct of consulting physicians and the quality of the examinations performed by those physicians. In response to my request, Social Security has expressed some interest in instituting its own investigation of the particular physician in question, and Congressman Whitley, whose district comprises the rural North Carolina counties in question, has asked Social Security to investigate this physician. My testimony today will focus on recommendations for strengthening the monitoring procedures of the State Disability Determination Section for insuring that physicians under contract with the Social Security Administration conduct thorough examinations of patients, perform all the diagnostic tests, laboratory studies, and objective tests necessary to accurately determine whether a claimant for disability benefits is indeed impaired by a disease process or injury, and further, to insure that the conduct and behavior of the consulting physicians is such that it preserves the dignity of the claimant.

DISCUSSION OF THE DEFICIENCIES IN THE EXISTING CONSULTATIVE EXAMINATION PROCESS

At the outset, let me make it clear that my intent here is not to offer a broad stroke condemnation of the consultative examination process now employed by the Social Security Administration; rather, my purpose is to offer a few recommendations that, if adopted, will refine and, I think, improve the current process with the effect of preserving the integrity of the consultative examination process by improving the quality assurance monitoring system employed by the State Disability Determination Sections for policing the consulting physicians.

The consultative examination process is big business, and as Chairman Pickle has pointed out in previous hearings conducted in September, 1981, it is one of the most important elements of the disability insurance program. Next year alone, the Social Security Administration expects to pay \$137,400,000 for these examinations and will refer some 40% of all disability claimants to consulting physicians. Moreover, as part of the continuing disability investigation process mandated by the Congress, Social Security has been and will continue to refer many recipients of disability benefits to consulting physicians for workups to determine whether the recipients are currently disabled and entitled to benefits. Preserving the integrity of the consulting examination process is indeed of vital importance as it involves the lives of recipients whose very existence is tied to these benefits, and likewise, it involves the lives of thousands of individuals who are no longer capable of performing their life's work and turn to the Social Security Administration for assistance. My interest in

testifying today grows out of my concern for the claimants for disability benefits and my growing conviction that at least with respect to general consultative medical examinations, the claimants, the Social Security Administration, and the taxpayers are not getting what they pay for.

Figures provided by the Social Security Administration on monies expended for consultative examinations in North Carolina indicate that the top ten volume providers received from \$20,000 to \$158,000 for conducting these examinations in 1981. Information provided us by the Social Security Administration in response to our Freedom of Information Act Request indicates that we have at least three of those volume providers within my eight-county service area. My investigation into the three leading providers of general physical examinations, especially the one provider who is the focus of our Freedom of Information Request, leads me to believe that many of the examinations conducted by these three leading providers are performed in a cursory and often rude manner. Specifically, I have found that the leading providers of general physical examinations in our area spend an average of 10 to 15 minutes per case examining claimants, and then a physician's examination will often consist of no more than perfunctory poking and probing of body parts, often neglecting the very body system that the claimant reports is the basis of his or her claim for disability benefits. These inadequacies in the examinations by the consulting physicians are many times masked in a report that by its form impresses the reader with the overall good health of the claimant under examination. Indeed, the reader of many of these reports will come away with the definite impression that the claimant under examination has no disabling problem whatsoever. Many of the reports by consulting physicians within our area who provide general examinations are masterpieces of form over content. As I have said, reading over a typical report of a general examination, you will feel that there is no basis for this individual's disability claim; however, if you scratch beneath the veneer of form to explore the content of the report and hence the examination on which it is based, you will find that the findings delineated in many of these reports are based on inadequate diagnostic procedures or the conclusions of the consulting physician are made without benefit of many of the objective, laboratory and diagnostic studies necessary to fully and comprehensively evaluate the claimant's condition.

These observations are derived from a study of many reports produced by the three leading providers of consultative physical examinations. Specifically, last year when we began serving six additional counties, I began to see many consultative reports by the physician in Congressman Whitley's district to whom I alluded earlier. I saw an amazing similarity in most of the reports generated by this internist. The reports produced by this physician had a boilerplate type similarity to them and projected the overall impression that the claimant had no real disabling problem. But when I began asking the claimants about what procedures were utilized as part of the examination, I found that this particular physician did not fully examine that body system which the claimant complained about.

For example, I recently represented a thirty-two year old woman who had been on disability for a number of years due to chronic asthma and sickle cell disease which produced a chronic and marked deformity of her right shoulder and knees. This lady was investigated by the Social Security Administration under the continuing disability investigation program and sent to the above physician for a general physical examination. Based on the report generated by this physician, which showed no evidence of limitation of the range of motion in the claimant's shoulder or knees or any evidence of asthma, the Social Security Administration terminated this person. When I showed this report to the claimant's orthopedic surgeon, he reported that the physician who examined the claimant at the request of the Social Security Administration could not have performed a full examination as x-rays and clinical studies performed by him showed conclusively that the claimant's right shoulder was deformed to the extent that it was wasting away and that she had an arthritic condition of both knees which required surgery on one knee just one month prior to the consulting physician's examination. Another physician who had been treating the claimant for some time reported that her asthma was so chronic and debilitating that she had been on Prednisone, a potent steroid used only in advanced cases of asthma, for some 16 years and she required a breathing apparatus to breathe properly. Three months ago, before her claim was fully adjudicated by an Administrative Law Judge, this claimant died as a result of a severe asthmatic attack which sent her into cardiac arrest. Yet, had we not had the resources by the claimant's treating physicians to serve as a check to the consulting physician's examination, we would have had a very difficult time proving that the examination of the consulting physician was grossly inadequate.

As a result of this case, we have instituted the routine practice of sending this particular consulting physician's reports to the claimant's treating physician for comments, and we have found an alarming number of cases where the treating physician pointed out that the consulting physician could not have performed a thorough and comprehensive examination as there were obvious deformities or disease process occurring within the claimant in question that the treating physician could document and the consulting physician found no evidence of a disease process.

We have also begun the practice of asking the claimant how long the examination took and what procedures were conducted as part of the examination. This practice has produced disturbing evidence that the consulting physicians, particularly the one in Congressman Whitley's district, did not perform the common diagnostic procedures that are a must for determining whether the claimant is afflicted by a serious disease process and to what extent the disease process debilitates the claimant.

For example, we recently represented a 60-year old woman who suffered a traumatic injury to her right knee some years ago that resulted in permanent damage to that knee. Her knee has never fully healed and is chronically painful and swollen. In fact, this claimant requires the use of crutches to walk around. Even a lay observer can see that her knee is swollen and when touched causes her considerable pain. Yet, the report of the consulting physician indicated no swelling, no pain with motion and no limitations in the range of motion of her knee. When I asked the claimant about this, she readily commented that the consulting physician never touched her knee and did not perform range of motion studies of her knee. This point was reinforced when I sent the claimant back to her treating physician who performed a routine examination and found marked swelling and pain of her knee as well as marked limitation in the motion of that knee.

The Administrative Law Judge who heard this case deleted the report of the consulting physician because it was based on what appeared to be fabricated evidence.

RECOMMENDATIONS FOR IMPROVING THE CONSULTATIVE EXAMINATION PROCESS

This brings me to my first recommendation for strengthening the consultative examination process. That is, that this committee and the Congress mandate that reports of consulting physicians be sent to the claimant's treating physician for comment. I believe that by referring the report of the consulting physician to the treating physician we will have a mechanism by which we can check for the accuracy and comprehensiveness of a consulting physician's examination, and we will also give the treating physician an opportunity to rebut the findings of the consulting physician by offering medical data on the claimant's condition which is often based on numerous examinations of the claimant. Through this process, a treating physician could not only offer clinical, laboratory, and objective data that rebuts the consulting physician's findings but also provide clinical expertise to the Social Security Administration as to whether the consulting physician performed all of the clinical procedures, laboratory tests or objective test studies necessary to fully evaluate the claimant's condition. In utilizing this very process over the past year, I have, as I noted earlier, found an alarming number of instances where the treating physician will report that the consulting physician did not conduct the full set of studies necessary to accurately diagnose the claimant's condition.

This is not the first time the Social Security Administration has received this recommendation. Recently, while researching this matter, I found a 1978 study conducted by six distinguished professors of law at the request of the Social Security Administration under the auspices of the National Center for Administrative Justice. The study, entitled "A Study of the Social Security Hearing System," published in a book entitled "Social Security Hearings and Appeals," by Lexington Books, carries with it a recommendation by the law professors that:

"Where there is a conflict in the treating physician versus the consulting physician's reports, it might be useful to submit the latter to the treating physician for comment. He is in a much better position to evaluate the consultative examiner's report and, in light of those findings, to supplement or explain his prior statements than anyone else in the system." (Social Security Hearings and Appeals: A Study of Social Security Administration Hearing System, by Mashaw, Goetz, Goodman, Schwartz, Verkuil, and Carrow, Lexington Books, D. C. Heath and Co., p. 59)

By enacting this procedure, you will create a procedural safeguard that will serve to protect the claimant and insure that the Social Security Administration obtains a detailed and comprehensive examination and report that honestly reflects the medical condition of the claimant at the time of examination.

In conjunction with this recommendation, I suggest that Social Security be required to send what medical information it has on a particular claimant to the con-

sulting physician prior to the consulting physician's examination of the claimant. Certain consulting physicians have voiced complaints to me with regard to Social Security's failure to provide them with any background medical information on the claimant's disorders. With this kind of information, the consulting physician would have some idea of the claimant's medical history and be able to concentrate on the body system about which there is documentation.

Similarly, many reports from consulting physicians carry with them laboratory studies, x-ray studies, or other special test results that indicate some degree of abnormality. However, in too many instances, the consulting physician's report does not contain any reference to the test studies. Likewise, where a consulting physician will find a number of physical abnormalities through clinical examination of the claimant, the physician will often fail to provide any summary of these findings whereby the physician attempts to analyze and interpret the findings to formulate a diagnosis or an evaluation of the claimant's degree of impairment. Without analysis and interpretation of the clinical findings and the laboratory and objective tests ordered in conjunction with a consultative exam, it is quite difficult to know whether the claimant is afflicted by a serious ailment or disease process, and whether that disease process impairs the claimant to the extent that it would qualify him or her for disability benefits. I recommend to this Committee that the Social Security Administration require consulting physicians to interpret and analyze the laboratory, x-ray, and other test results in the body of their reports in conjunction with the clinical abnormalities found through examination of the claimant and that the consulting physician's report contain an analysis and interpretation of this evidence along with impressions or diagnosis based on this evidence.

The next major complaint voiced to me by many claimants is that the consulting physician treated them in a brusque, rude or even hostile manner. At least one consulting physician in our service area has been accused by claimants on a number of occasions of manhandling them and forcing movement in a limb that causes them extreme pain. Yet, when you read the report on that examination, this consulting physician will state that there was a full range of motion of that limb with no evidence of pain.

Every notice sent to the claimant referring the claimant to a consulting physician should carry with it the name, address, and phone number of the professional relations officer with the State Determination Section. The notice should clearly indicate the right of the claimant to voice a complaint about the conduct of the consultative physician and the general quality of the examination performed by the consultative physician and the general quality of the examination performed by the consultative physician. Under the present system, claimants have a difficult time figuring out whom to complain to if they are treated in a rude manner that affronts their dignity. It should be made clear to them in the body of the notice of referral to the consulting physician that they have a right to be treated in a respectful manner, and if they are not treated in such a manner, that there is a person within the State Disability Determination Section who cares to hear from them about their complaint.

This recommendation too was offered by the distinguished panel of law professors in their 1978 report to the Social Security Administration. In that report they commented:

"It may be, however, that, even taking all these factors into account, the consulting physicians on some occasions are rude and hostile to the claimants. Even if this does not mean the consulting physicians are in fact biased, there is no reason the claimant should be subject to treatment of this kind. We do not know if the state agencies have any device for getting an evaluation from claimants concerning their consultative examinations. Such an evaluation or complaint system might help to insure the consultants treat claimants with appropriate consideration." (Social Security Hearings and Appeals: A Study of Social Security Administration Hearing System, by Mashaw, Goetz, Goodman, Schwartz, Verkuil, and Carrow, Lexington Books, D. C. Heath and Co., p. 59)

There is one final suggestion I have to make to the Committee. Why not send the claimant back to his treating physician for an examination and comprehensive report, and have the Social Security Administration make it known to the treating physician that they will compensate the physician at the level allowed under Social Security's fee schedule. The physician could thereby examine the claimant fully, order the necessary studies at Social Security's expense, and provide a report on the findings derived from this examination and studies. The report would also carry with it a history that is based on the physician's knowledge of the claimant's condition derived from numerous examinations. In the event that this recommendation is not adopted, I suggest that, at a minimum, the Social Security Administration be

required to send the claimant's treating physician a list of questions taken from Social Security's medical criteria (the Listing of Impairments) on the claimant's disorder and that the treating physician be asked to provide objective, laboratory and clinical data to support the responses on the questionnaire.

This recommendation grows from my observations that the state agency examiners often fail to see the severity of the claimant's condition simply because the treating physician does not word his report in the argot of Social Security's medical criteria or because the treating physician does not specifically note whether there is medical data that places the claimant within one of the medical criteria. A questionnaire would contain questions from the medical criteria which the treating physician could answer and thereby inform the state at once whether there was evidence to place the claimant within one of the criteria. What is more, the physician could estimate the claimant's limitation on this questionnaire.

SUMMARY

My recommendations are:

1. That the Social Security Administration be required to send the consulting physician's report to the claimant's treating physician for comment. This would allow the claimant's treating physician to comment not only on the content of the consulting physician's report, but also to add his own remarks from clinical notes and objective evidence he has compiled over a number of months and years in treating the claimant. In this way the treating physician could serve as a monitoring agent in checking the quality of the consulting physician's exam.

2. That the Social Security Administration be required to provide medical documentation on hand to the consulting physician prior to the consulting physician's examination of the claimant.

3. That the consulting physician be required to discuss and interpret in the body of his report the findings from laboratory, and other objective tests done as well as the results of clinical studies performed as part of his examination.

4. That the claimant be notified in the notice of referral to the consulting physician that complaints concerning the consulting physician's conduct toward the claimant and the quality of his examination can be directed to a specified individual whose address is listed on the referral along with a phone number.

5. That the Social Security Administration refer the claimant back to his or her treating physician for an examination and pay the physician for a full report on the findings, including laboratory and objective tests, derived from that examination. Additionally, that the Social Security Administration send the treating physician a list of questions from their medical criteria on the claimant's impairment.

Chairman PICKLE. Well, we thank you, Mr. Glancy. Your statement is a very interesting one, and your recommendations are very interesting. This committee will look at them seriously because you are active in the field. You see these people being referred and being examined. Your testimony should have authority to it and background to it.

I want to ask you this first. You complain about the consulting examination, that they are rude and claimants are kind of kicked about and shoved around. Who sends these people to the consultant examination?

Mr. GLANCY. The process is the person who believes himself to be disabled will go to the local Social Security office and file an application for Social Security benefits. That application goes to the State Determination Section. In our State it is a State agency, Department of Human Resources, under contract with Social Security, to evaluate the medical evidence in the case and render a decision.

Part of that process involves doctors who are under contract with this agency to perform these consulting evaluations. These doctors in the case, say, where a treating physician does not provide information about this person's condition or the hospital does not respond to the State agency's request or the information is inad-

equate to properly determine whether this person is disabled, the state agency will send a letter, a notice to this claimant saying that we have arranged an appointment for you with Dr. So and So on such and such a date, and they go.

Chairman PICKLE. That is my point. The State agency specifically directs this claimant to go to this consultant, examiner——

Mr. GLANCY. That is right. That is correct.

Chairman PICKLE [continuing]. To be examined, whether his disability claim is valid or not, so the State agency sends him to these persons. Now, if these consultative examiners give quick examinations or if they are rude or not considerate of the claimant, has that been reported to the State agencies?

Mr. GLANCY. I do not know how often it is reported. I know I have directed my——

Chairman PICKLE. Your attorneys, your paralegals, have they not complained?

Mr. GLANCY. Yes; they have.

Chairman PICKLE. What does the State agency or the medical profession say about that?

Mr. GLANCY. They write very nice letters and replies saying they will look into it and thanking us for bringing this to their attention, but I do not see that much evidence of any change as a result of the complaints.

Chairman PICKLE. Do the State agencies make referral to the consulting physician or—many of them are volume providers, I guess some of them are, because they cannot get people in the medical profession to give them a medical examination?

Mr. GLANCY. I am told that. I do not know if Social Security has ever looked into the process of just saying, well, you say here on this application that you see Dr. So and So, and contact Dr. So and So, Social Security contact Dr. So and So and say, doctor, would you do an examination for us, we will pay you? I do not know. There is an implied bias here that doctors who are treating somebody for a period of time will not be honest with Social Security. I object to that and I disagree with that.

I think that doctors I have contact with are men and women of integrity and that they would be quite honest in reporting just what they found in their examination. They would provide a more comprehensive look at the situation because their information would be based on repeated contacts with the claimant. I do not know if Social Security has ever looked at that, but that is what I would suggest.

Chairman PICKLE. Apparently the State agencies have chosen the process of sending them to certain physicians or volume providers because they are either available or it is the easiest or it is the only way to handle it. For whatever reason, that is what is being done.

Mr. GLANCY. Let me point something out here, too. I understand the position they are in. Some of these people like I represent are poor people who do not have a regular treating physician and there is no medical evidence in the record. If we do not have any medical evidence in a disability case, the State agency has two choices. Either deny because there is no evidence or send them to some doctor and get some information.

I am not here to say that you should not have that mechanism of having someone who can examine this patient and provide some information. I am saying there under the existing process, there is no quality assurance there, and often these doctors do not give you an accurate picture.

Chairman PICKLE. I see how they are being used, how the consulting physicians are being used. Now, the question is, if we take your recommendations I am wondering if we are not going to be accused of extending the processing time. If we take the very steps, the five steps you have recommended, it would seem to me like automatically you are going to extend the processing time twofold or threefold.

As I understand it, some of the attorneys in your State have objected to the processing time already. We have had some key legal tests in your State. So I think that is what we have to look at as a committee, are you unduly extending the process time.

Mr. GLANCY. Let me suggest this, that you use a device that is used in every other aspect of administrative law and court proceedings. You write the treating physician and say you have 10 days to respond, if you do not respond in 10 days, we will assume you have nothing to say and go on from there.

I do not think that what we are talking about will delay these proceedings especially when you consider that 70 to 80 percent of the people that go through the process right now at the two levels go on through a process that sometimes extends 2 or 3 years trying to prove something to the State Social Security Administration; and as a result of, I think, some of these consultative examinations being the basis for the determination, they lose much of what they have worked for all their lives and endure an incredible amount of physical and emotional pain.

Chairman PICKLE. I do not dispute that, but a lot is at risk and a lot is involved. We also have got to process them because of the large number that we are faced with, so it is a sort of a dual difficulty we face.

My 5 minutes is up. The Chair recognizes Mr. Bailey.

Mr. BAILEY. Thank you, Mr. Chairman.

The chairman has covered most of the questions. I just want to personally thank you very much. This has been an ongoing problem that we have been looking at. We have had a severe difficulty with it in Pennsylvania. The work that I have done has resulted very much in the kind of conclusions that you have reached. We have closely reviewed the entire process, examining everything, including rudeness, which seems to be partially based on the fact that when a person goes in for an examination, they expect some degree of thoroughness and it is not there, and as a result, there has been a lack of respect for the entire process.

You used the term quality assurance, and I think that is an excellent commentary on exactly what the problem has been. I compliment you for your remarks and your recommendation. I wonder, though, if you could pin anything down.

You have generically spoken of consultative examinations, volume providers in particular. Do you have specific experience with them and, if so, any recommendations? Are they worse or

better, in your estimation? And second, is there sufficient background with a treating physician in most of these cases?

The first question would be to compare the consultative exam process, on which you have made some excellent recommendations which I think should apply to all of them, if you have experience with volume providers for that type of service, whether they are worse, whether criticism of them can be segregated from criticisms of the general consultative examination procedure. That is question number one.

Question No. 2: Is there sufficient contact by a claimant with a treating physician in your experience to provide a sufficient connection for this more or less doublecheck idea, which I think is outstanding, or is it your experience that the consultative examination results sometimes, at least, from an insufficient information from the treating physician in the first place? Do you get my point?

Mr. GLANCY. Yes; I do.

Mr. BAILEY. Are we into a chicken and egg argument, at least in some ways? What has your experience been with it? And lastly, would you comment further on your relationship with Social Security? I have read over their stuff. We have had them here before. In fact, I specifically am going to request of the chairman that we get the Social Security people in here and force them to sit down and answer some questions on this process because they have done a woefully inadequate job of examining this process, of looking at it and providing information on it.

They have dragged their feet. They were supposed to have gotten questions answered last year, which they specifically did not. The questions that they got answered, the project they undertook to try to get questions answered about consultative examinations, and volume providers in particular, were totally inadequate and improperly done and yielded next to nothing.

I just wish you would respond a little more on what oversight you think Social Security ought to exercise.

Mr. GLANCY. I would be delighted to. Before I respond to that, let me point out something to you. In researching this matter a week or so ago, I found out that Social Security already had done 5 years ago what I just suggested. There is a study out that you might want to look at. It was conducted under the auspices of the Social Security Administration by six law professors. I quote that.

Mr. BAILEY. We are aware of that, Mike. They undertook to gather information last year. They did such a lousy job with it, it really is difficult for me to express the profanity to describe the job they did. But go ahead and comment.

Mr. GLANCY. The first question was with regard to volume providers and whether I perceived an inherent problem with the use of volume providers. First of all, in North Carolina the 10 top volume providers received from \$20,000 to \$158,000.

Through a Freedom of Information Act request that we have instituted, I learned that we have three of the leading volume providers in our district, and one of the persons I have used as an example today is probably one of the leading providers, but only in the general physical examination area do we have volume providers. The others usually have an ongoing practice and they cannot afford to see 5 to 10 of these folks a day.

The volume providers in the general physical area as a general rule do not have much of a practice, and if they did not have Social Security they would not have much. They are deriving probably, I would imagine, from 50 percent on up of their income from Social Security.

Mr. BAILEY. They are geared to it, and therefore the criticism you are making about dealing with the initial treating physician is to try and provide information so that that treating physician orients himself more toward what Social Security is looking to on disability standards. I understand that. That is an excellent recommendation, but could you compare the volume providers and non-volume providers?

Mr. GLANCY. I think there is an inherent problem with the volume providers in that there is no way on Earth you can do a competent job of diagnosing anybody in 10 minutes, and many of these people you have already heard about, the Thurmans and other people, are bigger volume providers than anybody I have in my area. There is just no way you can see 50 people in a day, 10 minutes a shot, and say anything about that person. Any physician worth any respect will tell you in a minute that there is no way they are going to give you a competent diagnosis of a person in 10 minutes. That is an inherent problem in the system.

The problem, then, proceeds to these volume providers who have a very skilled way of masking this limited contact. The form of these reports is a masterpiece of form over content. If you scratch beneath the form, you find what I found, that there is nothing there. They know what to say, they know how to say it, they put it in a standard format that many treating physicians do not know, and they put it in the language that the Social Security Administration is not familiar with.

Many times the treating physicians are providing the clinical facts, but they are not putting them in terms of the criteria Social Security deals with, so they are thrown out. The volume provider knows how to say it, knows what form it is to go in, and this not only results many times in denials but also many times hides skillfully the fact that the volume provider did not do what they should do or did not conduct the detailed examination they should have conducted to really accurately determine what is happening.

So in that regard I would say definitely there is an inherent problem with any system that allows a physician to get 10 or 15 or 20 or more referrals a day and expect them to do a competent job within 5, 10, 15 minutes, particularly where they get no history and then in the body of the report they do not even bother to interpret half of what they have done. I do not know how Social Security does it.

Chairman PICKLE. The time of the gentleman has expired.

Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman. I want to commend you for having these hearings.

Mr. Glancy, I want to thank you for being here. I guess being a Congressman I must spend more of my time working with these problems than anything else. Every time I go home, I am unfortunate enough to have to sit down with very impassioned people who have been turned down. I know the treating physicians to be hon-

orable, very capable physicians who have found them to be totally and permanently disabled. Meanwhile, somebody gets one of these 5-minute propositions you are talking about and is turned down without a physician ever even looking at the medical history.

So I know the problem first-hand and I want to resolve it in the worst way to do something to try to make the system work better than it is working now.

I thank you for your specific suggestions. The first four of them I can readily agree with. Do you have any evidence from your contacts and your experience as to what the increased cost would be to implement one through four? Obviously, number four would not cost anything. It would be just a matter of putting another line on the form or something. Numbers one and two could conceivably cost additional time in terms of the consulting physicians having to take a look at it.

Mr. GLANCY. Are you saying the costs of sending the consulting physician's report to the treating physician asking for a response? Is that your specific question?

Mr. MOORE. I did not understand number one to say that you had to do that. It would simply be up to the Social Security applicant's desire to do that.

Mr. GLANCY. My suggestion is that it be mandated that the State agency send the consulting physician's report to the treating physician, and that would be a means of monitoring the performance and gathering more information.

Mr. MOORE. Do you have any idea what the costs would be to do that?

Mr. GLANCY. I have no idea. I assume the cost is in mailing.

Mr. MOORE. The reproduction of the report, or whatever.

Mr. GLANCY. Yes; what the costs would be, I do not know. I do know, without meaning to sound trite, I know the human costs that you know because of the existing program. I know of the suffering that goes on because of the inadequacies.

Mr. MOORE. We all do. I am in full agreement with you on that score. It is just that we are going to get clobbered by OMB and whatever walking into something like this.

Mr. GLANCY. They are paying \$137,400,000 for this process right now, and in many cases in my experience they are not getting nearly what they are paying for. I think if they monitored it closely and used this mechanism, they could see that their \$137 million is better spent.

Mr. MOORE. The way the law is now, I understand the claimant cannot see the consulting physician's report at all; is that right?

Mr. GLANCY. I think the claimant could see it if he went into the district office after he has been denied. He is not allowed to see it prior to the denial. The consulting physician's report is sent right to the State agency, where a decision is rendered. The file is then sent, after it is denied, to the local district office, and the claimant could go in there, I should imagine, and say I want to see that file and do that.

Mr. MOORE. That documentation, item No. 2 and item No. 3 would require additional consideration by the consulting physician, which I think should be done. I agree with you. Do you have any concept of the additional time it would take for the consulting phy-

sician to look at the medical documentation that the applicant has filed with Social Security, and also to third in its report discuss any, I guess, laboratory or objective tests the consulting physician has ordered?

Mr. GLANCY. What I am talking about here is standard medical practice everywhere else. If I am Doctor Z and I am an internist and I have a patient who needs orthopedic care and I refer them to you, I would commonly write you or at least send you the medical history to tell you something about this person.

You will read it, as a standard medical practice, so you will know who this person is. You do not treat somebody cold. You try not to treat somebody cold. If you order tests, you do, as a standard medical practice, bother to interpret them, otherwise they are not worth a hoot. You do not know what the diagnosis is if you do not look at the lab studies or the X-rays and comment on them.

Mr. MOORE. Do you have any concept of the additional time required? I am sure the doctors who do this will testify subsequently in the hearing that this will require additional time and the fee will have to be increased.

Mr. GLANCY. I have no question that it will require additional time, but I am saying that it is a shallow argument because it is something that is common practice in the practice of medicine that has to be done to accurately diagnose, and if they say it takes 5 more minutes, I am sorry, but we are talking about somebody's life here. If you want to do it properly, you do it with respect to the history.

Mr. MOORE. Would you explain the fifth point? Are you saying that after the consulting physician's report, the Social Security Administration then pays to have the treating physician go back through this?

Mr. GLANCY. No; I thought about this later. This is in place of the consulting physician. Why not write the treating doctor and say we will compensate you, doctor, at the rate our fee schedule allows now to examine this person and provide a report, and with that please give us the details from your previous contacts.

Mr. MOORE. You have no fear that the treating physician might be a little too lenient towards the applicant's case than a third party physician who is not the treating physician?

Mr. GLANCY. I think that the treating physician is a man—and this is from the experience of having dealt with many physicians—a man or a woman of integrity. They will tell you what they find. You can ask them what you ask a consulting physician. We want the standard orthopedic test. A range of motion study is a range of motion study. They will tell you that there is 30 degrees movement in an arm or a leg and they will report honestly about it.

I do not think—and this is what bothers me about social security—that there is an inherent predilection on the part of a treating physician to lie to help his client. I do not think that. I think you could rely on it. I think, though, and this is the problem that probably bothers social security, that the treating physician has more of a tendency to weigh all of the factors to know exactly how this problem impacts the life of this person. By that I mean that this guy cannot walk across the street, I know he cannot walk

across the street because he just collapsed in the street last week and I had to look at him in the hospital.

Mr. MOORE. I know my time has expired.

I would just conclude, Mr. Chairman, by saying that I agree with items one through four that the gentleman has brought to our attention.

The fifth point concerns me because in my years of practicing law and handling personal injury cases, we did run across doctors who would, to say the least, be very lenient in terms of describing the disabilities of the patient. I think there is something to be said for having another doctor do the reviewing, although I am most unsatisfied with the way that system is working now.

Mr. GLANCY. Could I add something to that? The other thing I mentioned earlier is the treating physician does not know the terminology that social security looks at. The simple fact of sending the treating physician a questionnaire that is built on the points in the medical criteria that social security is looking at and asking specific questions around those points, the treating physician could respond on the basis of his clinical findings, submit those clinical findings with his responses, and you would have a clear picture right off the bat from the treating physician whether he feels or she feels this claimant meets the medical criteria.

Right now it is just doctors are practicing medicine and they have no earthly idea what terms social security is looking for or what format they are looking for. They just send it in and say here is the information and here is what I think it says. If it does not say exactly what is in the medical criteria, you are out the door, and it is months or years later and finally a judge or somebody says what is the difference between what Dr. So-and-So said and what Dr. U said? You will find there is no difference.

Chairman PICKLE. The time of the gentleman has expired.

Mr. Glancy, we thank you for your testimony. You have made some very positive recommendations. You have also made some very strong statements. We are glad to have them on the record and we will keep in touch with you as these hearings proceed also.

Thank you very much.

Mr. GLANCY. Thank you very much for having me.

Chairman PICKLE. The next witness is Mr. Michael Lomax. Mr. Lomax is president of the National Association of Disability Examiners, or NADE, as we refer to them.

Will you identify the gentleman with you, Mr. Lomax?

STATEMENT OF MICHAEL LOMAX, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS, ACCOMPANIED BY MARTY BLUM, LEGISLATIVE CHAIRPERSON

Mr. LOMAX. Thank you, Mr. Chairman.

This is Marty Blum, who is our legislative chairperson for the National Association of Disability Examiners, and Marty is here to consult with me as we talk about this.

Chairman PICKLE. We are glad to have you, Mr. Blum.

Now, Mr. Lomax, you may proceed. Do you care to generalize your statement? Or do you want to follow your testimony?

Mr. LOMAX. Thank you, Mr. Chairman.

I have submitted a formal statement that I would like incorporated into the record, but I am also going to preface that with remarks from that particular testimony that I have.

Chairman PICKLE. Your entire statement will be included in the record.

Mr. LOMAX. Thank you, sir.

The claims process involves a multiple of different decision processes to insure that the disability claims are adjudicated accurately and expeditiously. Examiners strongly believe in the expediting of the disability claim for the sake of the claimant and other possible beneficiaries that are involved. The increasing amount of claims handled by the State agency, state-imposed hiring freezes, uncertainty of budget funds on a quarterly basis, performance standards, accelerated cases, profile, and now the periodic review cases all are in combination leading to the confusing process in the development of the claim. Many times the records that we have obtained in connection with the medical records from the attending physician only involved the treatment program for the physician's patient.

Sixty percent of these claims can probably be adjudicated on information supplied by the attending physician, the hospital clinic and other related health facilities. The other 40 percent of the claims require a consultation for further investigation into the allegations or evidence secured by the examiners.

In many instances, the attending physician may not have the necessary equipment to perform the required examination. Many private physicians just do not have the time for the social security disability. Some of these physicians grant a State agency block time or setaside time to provide examinations.

In less populated areas of the country this has resulted in long delays in the scheduling of appointments, the securing of the report, and the adjudication of the claim. In some instances it would not be uncommon to get an examination appointment 6 weeks in the future.

Others have completely specialized in the practice of disability evaluation and performed only examinations for the State agencies. A combination of these practices has been left solely to the responsibility of the State agency at the present time.

This ever-increasing emphasis by SSA, for thorough documentation and documentation in compliance with the listings of impairments, has become imperative that the DDS be able to obtain the reports and testing coinciding with those listings. Many private physicians are unable to routinely provide detailed reports with objective findings as required for disability documentation, and examiners must spend more time clarifying information and monitoring individual reports to try to improve the quality of these reports.

The use of highly specialized physicians has been defined by officials as being volume providers; yet we as disability examiners do not see where we have adequately defined the term of a "volume provider." I believe SSA has established a working definition of volume provider as a physician doing 10 percent of the CE business, or \$100,000 per year, or whichever comes first.

Another problem the examiner encounters is the definition of "examination" and what constitutes an examination. If an examiner needs to document the claim currently, lab work or current X-

ray findings, does this constitute the examination? If the examiner needs to buy a full internist examination, such as lab work, chest X-ray, X-ray of two involved joints, treadmill, pulmonary function studies plus a consultation by the physician, it may cost close to \$500 for all these procedures but yet count as one examination.

Which is more reflective of the CE process involved, a CE per case as it is reported currently or the cost per case? In some States each medical vendor will require a separate contract for the services they will provide. The physicians set up with the equipment to perform the lab work, treadmill, X-rays, and consultation will receive the entire portion of the fees that may have been previously split between the vendors I so named.

This physician could easily and very quickly reach the definition we are talking about here as a volume provider. Volume providers have tailor made their operations toward the documentational needs of the DDS. They have been more responsive to the changes in the program requirement. State agencies have been working with undefined rules that address the very nature of these hearings, and States have responded to the crisis of monitoring the physicians by the accounting practices, medical review of the reports, and interviewing the claimant after the examination.

The advantages are outlined on page 4 of my report regarding the volume providers. We, also, believe that all medical providers, whether volume or not, need to be monitored to insure the quality of the information, the objective evidence that is in the reports, the quality of the treatment of the claimant at the time of the examination, and the timeliness of the reporting of that particular examination.

The examination should be performed in a routine manner established by required guidelines. Some States have been using routine guide forms in the examination process to insure that the findings are reported accurately. Several States have developed guidelines for the volume providers, and how they are outlined is on page 5 of my particular report. These are only a few of the guidelines that some States have established at this point.

The National Association of Disability Examiners has outlined the important aspects of volume providers and the important role they play in the documentation and adjudication of disability claims on a timely basis. The examiners and staff in the disability field are encouraged to use the sources that gives the most accurate reports in the shortest period of time to meet the performance standards placed on the examiners and States by the administration.

Without the help of volume providers, the State agencies would fall far short of the goals and minimum performance standards established by SSA. We conclude that there have been definite problems in the volume provider concept and how they have been used. The outline has focused on definite needs for the volume provider and, also, on the area of monitoring the volume provider.

We can definitely state that improvements have been made in the areas outlined above and the process is continually being refined to meet the criteria of the State DDS.

Thank you, Mr. Chairman, for my oral part.

[The prepared statement follows:]

STATEMENT OF MICHAEL LOMAX, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Mr. Chairman, thank you for allowing the National Association of Disability Examiners to present our views on the "Volume Providers".

As you know the State agencies are involved in the process of developing and adjudication of disability claims for the Social Security Administration under title II and title XVI of the Social Security Act.

The claims process at the state agency level involves a multiple of different decision processes to insure the disability claim is adjudicated accurately and expeditiously for the benefit of the claimant. The disability Examiners strongly believes in expediting the disability claim for the sake of the claimant and other possible beneficiaries involved.

Throughout the years there have been a number of factors that have contributed to the documentation process directly or indirectly. The increasing amount of claims handled by the State agency, State imposed hiring freezes, the uncertainty of budget funds on a quarterly basis, performance standards, accelerated cases, profile cases, and now periodic review cases all or in combination lead to the confusing process in the development of the claim.

The first step in the development process is to try and secure the medical records from attending physicians and hospitals so named by the claimant. Many times the records obtained in connection with the medical records from the attending physician only involve the treatment program for the physician's patient and do not contain the necessary objective findings required by the Social Security Regulations to meet the requirements of disability for or against the claimant. We are not faulting the attending physician for the lack of medical records as the physician is in practice for treatment of the claimants condition and general health and not for the detailed information required by SSA.

Naturally in the process of reviewing the claims process certain amount of claims (60 percent) can be adjudicated on the information supplied by the attending physician and the hospital, clinic, and other related health facilities. However, there are the other 40 percent (percentage determined by SSA) of the claims which require a consultation for further investigation into the allegations made by the claimant or by evidence secured by the examiner during the development stage.

This process involves the arrangement of a specialist examination to be performed by the claimants own physician or by a physician appointed by the State agency. In many instances the attending physician may not have the necessary equipment to perform the required examination (i.e., treadmill, pulmonary functions, X-ray, extensive lab work, etc). If this type of equipment is not available through the attending physician or the attending physician wishes not to do the examination, the State must arrange with a third party to perform the type of examination required for documentation purposes.

Throughout the years the state agency has used a variety of consultant physicians to perform the work required to meet the demands of the state agency. Many private practice physicians just do not have the time to devote an hour out of their work schedule to see a claimant for social security disability when a physician can examine six or seven regular patients in that same amount of time. To the physician it is not cost effective and would just as soon not provide this service to the state agency and social security.

This has promoted some physicians to grant the state agency "block time" or set aside a time (one day a week or every other week) to provide five, six or seven exams to the state agency. In less populated areas of the country, this is and has resulted in long delays in the scheduling of appointments, the securing of the report and adjudication of the claim. In some instances it would not be uncommon to get examination appointments six weeks in the future.

Other physicians have specialized in the field of disability evaluation and combined the reviewing of disability claimants with their part time practice for the general public. Still others have completely specialized in the practice of disability evaluation performing only examinations for the Social Security Administration through the direction of the state agency.

A combination of these practices are incurred by the state agency in the development and adjudication of the disability claim. The combination of these practices has been left the sole responsibility of the state agency to secure the source to provide the objective, detailed medical evidence on a timely basis.

With the ever increasing emphasis by SSA for thorough documentation and documentation in compliance with the Listing of Impairments, it became imperative that the DDS be able to obtain reports and testing coinciding with the Listing of

Impairments. Since many private physicians are unable to routinely provide detailed reports with objective findings as required for disability documentation, examiners must spend more time clarifying information and monitoring individual reports to try to improve the quality of the reports. Private C/E physicians are also unable, in many instances, to acquire the necessary testing needed for documentation or supply the testing within the established state fee schedules.

The use of highly specialized physicians has been defined by officials as being volume providers. However, we as disability examiners, do not see where SSA has adequately defined the term of volume provider. I believe SSA has established the working definition of volume provider as a physician doing 10 percent of the C/E business of a state agency or \$100,000 per year in medical fees whichever occurs first.

Another problem the examiner encounters is the definition of the examination. What constitutes an examination? Does it require the physician to be with the patient 30 minutes in consultation to take the history, physical, and examination to complete the necessary documentation required? Should the exam be an hour?

If all the examiner needs to document the claim currently is lab work or current findings on x-ray, does this constitute an examination? State agencies are asked to report to SSA each time they buy an examination on a claim. If an examiner needs one lab test to confirm the findings, does this constitute an examination? If the examiner needs to buy a full internist examination, (such as lab work, chest x-ray, x-ray of two involved joints, treadmill exam, pulmonary functions tests plus the consultation by the physician) it may cost the examiner close to \$500 for all these procedures but yet count as one exam? Which is more reflective of the C/E process involved, a C/E per case or the cost per case?

In some states each medical vendor will require a separate contract for the services they will provide as in the example I just quoted above it may require six separate vendors to complete the entire examination. Six separate vendors will receive payment for the services rendered for their part in the examination. To the SSA this still counts as one examination. The point I am trying to make is the Physician set up with equipment to perform lab work, treadmill, x-rays, and the consultation will receive the entire portion of the fees that may have been previously split between six different vendors. This physician could easily and very quickly reach the definition of a volume provider.

To the examiner involved in securing the necessary objective evidence to support the decision would more than likely go to the source who can provide all the necessary findings, and do it in one contract instead of six.

Since volume providers have tailored their operations toward the documentation needs of the DDS, they have been more responsive to changes in program requirements and more receptive toward providing quality and objectivity in their reports. They are also responsive to complaints and are willing to alter operations for better service to claimant and the DDS.

The combination of factors outlined above has prompted the states to take the necessary steps to insure the reports are provided in a timely manner and this is being accomplished in the larger states with the volume provider.

Naturally with the larger number of caseloads in the larger states it will require a larger number of examinations to be performed. This is being accomplished by the volume provider that can supply the agency with the needed information in one examination as opposed to several different examinations at different locations.

The state agencies have been working with undefined rules that address the very nature of these hearings and that is the monitoring of the volume providers. States that have large uses of volume providers have responded to the crisis of monitoring the physician by accounting practices, medical review of reports and the interviewing of the claimant after the exam plus other imaginative criteria developed by the DDS's.

Some of the advantages examiners and staff working in the state agencies have by using volume providers include:

- A. Necessary testing can be done in accordance with SSA requirements.
- B. Physical findings and objective data are reported in a manner which is readily applicable to SSA criteria.
- C. If the physical examination reveals previously unknown problems, the doctors will request the appropriate objectives testing, thereby avoiding the need for return visits or additional C/E's.
- D. Significant staff time is saved by prescheduling examinations throughout the day for claimant convenience.
- E. Missed appointments or problems are reported to DDS immediately.

F. The majority of tests are done at the time and location of the examination which saves the claimants from having to make several trips or go to more than one facility.

G. Most reports are received in the DDS within 10 days of the examination.

H. It is easier to monitor reports and provide timely feedback to the provider.

I. Because of the volume of tests done, testing is more readily purchased for fees within the states fee schedule.

However we also believe that all medical providers need to be monitored to insure the quality of the information and the objective evidence made in the reports, the quality of the treatment of the claimant at the time of the examination, and the timeliness of the reporting of the examination.

These examinations should be performed in a routine manner established by the requirements outlined in the POMS for the examination process. SSA should offer detailed guidelines that can be used by the consulting physician in the performance of a contractual agreement to provide the necessary objective findings. Some states are now and have been routinely been using a guide form for the consulting physician to use in the examination process to insure the needed medical findings are reported accurately and to the specifications as outlined in the Listings of Impairments.

Several States have developed guidelines for the use of volume providers and how the volume provider will be used for example:

1. No more than three exams should be scheduled or performed per hour.
2. The physician should explain the purpose of the examination, that the results will be considered with other medical and vocational evidence and no attempt should be made by the physician to predict whether the patient will be found disabled.
3. The examination shall be conducted in a manner similar to that of a private patient, with genuine concern being shown for the patient's complaints and feelings.
4. Training of office staff for proper performance of the various functions is the responsibility of the physician.
5. The report must accurately reflect what occurred during the examination.
6. The physician must submit a curriculum vita to the state agency and be approved for competency by a consultative physician committee before they are authorized to perform exams.
7. The purchase date and maintenance history of all major medical equipment will be posted near each machine.
8. The examination report must be compiled and signed by the examining physician only after reviewing x-rays and laboratory findings.
9. The report must accurately reflect what occurred during the examination and be tailored to the examination without the inclusion of unnecessary verbiage serving no real purpose.
10. Should a particular physician become lax or indifferent to our needs the volume sources would have the responsibility of resolving the problem or replacing the physician.

In conclusion the National Association of Disability Examiners has outlined the important aspects of the volume providers and the important role they play in the documentation and adjudication of disability claims on a timely basis.

The examiners and staff in the disability field are encouraged to use the sources that give the most accurate reports in the shortest period of time to meet the performance standards placed on examiners and states by the Administration.

Without the help of these volume providers the state agencies would fall far short of the goals and minimum performance standards established by the SSA.

We conclude there have been definite problems in the volume provider concept and how they have been used. The outline above focused on the definite need for the volume provider and also on the area of monitoring of the volume provider. We can definitely state that improvements have been made in the areas outlined above and the process is continually being refined to meet the criteria of the state DDS.

Chairman PICKLE. Mr. Lomax, we thank you for your testimony and for the recommendations and observations you have made in it.

You state at the beginning of your testimony that the use of highly specialized physicians has been defined by officials as being volume providers. Do you think that the State agencies are sending these people to highly specialized physicians under the present method used under the volume provider process? In other words,

are our volume providers that we are using that are operating today, are they highly specialized physicians?

Mr. LOMAX. They are highly specialized in the area that this is the only type of work they are providing, examinations for the State agencies, highly specialized in the area of just disability evaluation alone.

Chairman PICKLE. Do you as a representative and president of this national organization approve of the Johnson-Byers-type volume provider operation?

Mr. LOMAX. I approve of the concept of volume providers. I do not exactly approve of the Johnson-Byers method in the way the examinations have been reported and the methods in the past. There needs to be a monitoring process most closely related to what is needed as far as evaluation concepts are concerned.

Chairman PICKLE. We have other volume providers other than Johnson-Byers who have been brought under consideration through these hearings. What you are saying about this group would be applicable, certainly, to other volume providers, that you have at least examined up to this point?

Mr. LOMAX. Right.

Chairman PICKLE. In our testimony in our September hearings on volume providers, two State agencies, I think they were Tennessee and—

Mr. LOMAX. Pennsylvania.

Chairman PICKLE. They testified about the low fees that were paid under the program. They suggested that this had been one of the reasons volume providers had to be used. In one State the fees were last changed in 1974, the other 1978. How could we deal with this problem? Is the fee a serious aspect of this difficulty we have?

Mr. LOMAX. The fee is a definite handicap in some particular States in which we do not and have not evaluated the concept of how much we will be able to pay for a consultant examination and the lab work and so on and so forth. In some States they have not been revised in several years. In other areas they are also couched and are considered along with other State fee schedules, and the State agency is bound by whatever the State could pay at that particular point in time.

For example, I can go across the border and buy the same examination for more money because that consultant lives across the State boundary and I can pay whatever they can pay in that State for the same type of exam, but I cannot pay in my State because of the problems with the fee schedules among States.

Chairman PICKLE. When you say "across the border," the State border?

Mr. LOMAX. Correct. I do not mean going to Mexico, no.

Chairman PICKLE. Well, we in this committee have just introduced a bill with respect to disability corrections or reform, primarily procedural aspects, H.R. 5700, and we have been advancing a new idea to pay for consultant exams through a fiscal agent who would pay for the examinations on the basis of the prevailing charge in the locality where the service is being performed and to pay for it under medicare.

Would that help? Would that be an improvement? What is your view of that approach?

Mr. LOMAX. I agree with the prevailing concept. I think it should be introduced as an alternative to the State agency fee schedules that are imposed upon States at the present time. The prevailing fee concept would certainly help in this particular area. I do not agree with your fiscal agent concept, though.

Chairman PICKLE. Do you agree with the statement made earlier in the testimony brought out in these hearings that consultant examiners or volume providers cannot properly make 25 to 35, 40 examinations a day and adequately give that claimant a thorough examination?

Mr. LOMAX. I agree with the idea that probably a volume provider cannot do that many examinations in a day. Keep in mind in that particular practice there may be more than one particular physician in that group doing examinations of that particular nature. Also, there are other probably related individuals who are taking histories, physicals, lab work, X-ray, treadmill, pulmonary function, all these other tests that are needed to do the examination part of it.

The physician is doing the consultation aspect of that particular claim. Physical histories are taken by someone else. They probably can do several examinations in a particular day. We are probably thinking that the particular day is 8 to 5, where some physicians may be working from 7 in the morning until 10 at night or in combination with several physicians in a particular group.

The number of examinations has to be borne out here. What do we look for in examination? What is included? For example, if I was doing only lab work and only needed specialized laboratory tests to determine the conclusion of a particular disability evaluation, I could probably do several per day, 25 or 30, but when you combine that with a consultative examination and so on and so forth, yes, I agree, you probably cannot perform that many per day.

Chairman PICKLE. Mr. Lomax, I do not find the answer very satisfying. You wandered all over the pasture. The fact is these volume providers are making 30, 35 examinations a day. In some cases they make 50 and 60. I am just trying to say to you: Is that good policy? Is that individual apt to get a thorough examination under those circumstances?

Mr. LOMAX. Definitely not. As I have outlined on page 5, one of the recommendations States have come along with is no more than three exams should be scheduled per hour.

Chairman PICKLE. You list those guidelines on page 5, as you said. I see that you say here, they are guidelines. Where are these guidelines in effect? What has been their impact on volume providers in the States where they are operating? Are they functioning? Are they operating?

Mr. LOMAX. I have contacted several States that are using volume providers and asked them exactly what areas are they looking at now. The States that I contacted for this information was the States of Tennessee, Indiana, Michigan, and Illinois. In these particular States I asked them as to what guidelines they are using currently for volume providers, and of that compilation I have listed here on page 5 some of the guidelines that the States are now imposing upon the use of volume providers.

Chairman PICKLE. Mr. Lomax, I am going to take another minute of the committee's time before I recognize the other members. I just want to run this general scenario by you. The SSA office sends notices to beneficiaries that they should be examined. They send them to a volume provider and then to a moving van, a moving hospital, so to speak, and this is what happens.

They will call these people in—25, 30, 50 of them. This has been happening in Pennsylvania. They come in for an examination. Quite often in the van there is not a physician in attendance. There are some medics, some X-ray people and others. They give an examination. No physician is in attendance.

The forms are filled in pretty much in shorthand by the word process of what to put in those blanks. Then those examinations, those forms are sent to another State, in this particular case Florida, where a physician looks at them. They transcribe them, put the data in the slots, and the physician looks at them.

He looks at the X-rays in some cases, and we do not know when they go from that van—the X-rays are made and sent to another State—whether they are good X-rays or not. They are just made. There is nobody in the van to tell whether they are good X-rays, whether there is too much light, not enough light, whether it is a valid X-ray or not. Six or eight States send them down there and the physician looks at them. He fills it out.

Then he sends it out or maybe he signs it. He sends it up to the other physicians who run these volume providers and they look it over and sign it. He does not have the physician with him. He does not have the records with him up there where it is finally approved. The records are not with him. He just looks over the analysis and signs it.

Now, my question to you, sir, is this. You are president of this National Association of Examiners. Is that a good procedure?

Mr. LOMAX. No, it is not, and Mr. Blum will field the rest of my question.

Mr. BLUM. If I could just supplement and respond to that question, no, we do not endorse the practice that you outlined, and which was part of the testimony in September on the Johnson and Byers setup.

Chairman PICKLE. Am I overstating?

Mr. BLUM. You may not be overstating the practice of one particular volume provider. However, I would add that I do not believe that this practice is typical of the volume provider operation in the various States throughout the country. I do feel that the picture that you have gotten so far might be somewhat distorted in terms of the many volume provider operations which do not follow that practice.

Chairman PICKLE. Do we have many volume providers over the country?

Mr. BLUM. Yes.

Chairman PICKLE. In what States? Do you have a list of them?

Mr. LOMAX. Mr. Chairman, we really have not identified our concept of a volume provider yet, nor have we had any guidelines from anybody to determine exactly what constitutes a volume provider. It is undefined. Every State I contacted had something different to say as to what their particular definition of volume provider was.

That varies from State to State. It is hard to determine exactly what volume provider means.

Chairman PICKLE. I want to recognize Mr. Bailey and Mr. Moore if you have any questions, but let me just say I do not want to overblow the situation. What I have outlined to you has been the procedure in one or two of the people called before this committee. We are not going to tolerate that, and I want you to know that, and I hope you do not engage in that kind of practice. If you do, we are going to get after you, too.

But in our effort to clean it up we must not be unfair because there is a need for them, obviously, because there is a lack of good examiners available. I hope we can get this information, that you do not try to roll with the punch and defend the process I have outlined, because if you do, we are going to have to have further examinations on it.

Mr. Bailey.

Mr. BAILEY. Thank you very much, Mr. Chairman.

I cannot add anything to what the chairman has said except to say that I endorse every single thing that he said to you 100 percent. I think he is completely correct. I think that you discredit people who probably—and I know you came here very good naturedly and I know you are very courteous and have presented a good general view of the profession or of the practice, but I think you had better keep an eye on some very proper criticisms that have arisen.

I could go through some of them, but there is no need to—apparently you were here during September. You know the testimony on that Pennsylvania case. The examinations were up to 65 on one particular day, and everything the chairman says is totally correct about how it was conducted and how the process works.

I think we need some constructive criticism, advice, and help from you folks. We know there are good people out there, but they are not the problem. What is the reason for a consultative exam? If it is to provide additional medical evaluation and evidence to help some official in a judicial or quasi-judicial capacity to make a decision on disability, then the emphasis should be on quality.

There is also the responsibility to claimants, the taxpayers, and the whole system to do a decent, good, and proper credible job. That is not being done, and you folks ought to be helping with the effort to get it straightened out because you know darned well it is not right. As you said, you cannot defend it.

I just want to end by endorsing what the chairman said. I think he is right on target.

I invite any comment. I do not mean to cut you off.

Mr. LOMAX. We are endorsing the concept that the volume providers are definitely needed. We are not endorsing those that have bad practices as far as some volume providers have provided in the past. We are definitely interested in the areas of monitoring volume providers and how they submit their reports and the quality of those reports.

The agencies that are conducting these particular examinations or contracting out with these areas have established on their own some guidelines in this particular area of monitoring volume pro-

viders on their own and the fact that there have been no guidelines that have come down from SSA so as to determine what——

Mr. BAILEY. I know what you are going to say about social security. The chairman is very pressed for time and I am trying to cooperate because I get a little windy now and then.

I hope that you will try to provide what input you can to the Social Security Administration because I think they should provide some guidelines here. They have not really done so and certainly have not done so specifically. I knew you were going to get to that, and I am glad you did and we expect your help and cooperation in seeing that they do that.

Mr. LOMAX. We will make our input to them.

Mr. BAILEY. I thank you very much.

Thank you, Mr. Chairman.

Chairman PICKLE. Mr. Lomax, I do not want to appear harsh to you about what is happening because you are not setting these procedures. I think the difficulty in many respects that we face is that we do not have enough physicians locally who are available for the various examinations, and by practice and almost necessity the State agencies select the volume providers, who could be very highly specialized physicians, as the guidelines indicate, but because they cannot find them, they go to this sort.

I do not know whether the medical professional is proper in their attitude about the volume providers or not. I have not looked into it in that depth, and I am not going to accuse the profession of having a cavalier attitude about these examinations; but we cannot allow these quicky examinations, the volume examinations, and either the State agencies or the medical profession or the examiners or the Congress have got to find a better system or a system that has good standards. They have either got to be State standards or medical standards. We have got to get them in force.

So I am saying to you I hope you give us your recommendations and suggestions. You are out in the field. You see how these things are going on. We want more information. We ask you, though, not to be hesitant or bashful in giving information to this committee that will be helpful.

Mr. LOMAX. As I said, States are using guidelines to physicians that are doing the examinations as to what is required in the examinations and to follow the guidelines.

A comment was offered earlier about sending out to the attending physician the information that is needed in a particular medical report so that could be reported back to the State agency. In many States that is being done now, and the question is they go out to attending physicians asking them for information regarding a particular claimant, and many times those come back incomplete, unfilled out, and are usually referred to "see medical records attached," which does not offer a solution to the problem that the State agencies currently have in getting the necessary documentation needed for the disability claim.

Chairman PICKLE. I was glad to get your guidelines and your recommendations, but as I asked you earlier, where are these guidelines into effect now? Are they in effect now?

Mr. LOMAX. I know of a couple of situations that I have submitted in my report here that one particular State will put them into effect July 1 of this particular year.

Chairman PICKLE. Of 1981?

Mr. LOMAX. 1982.

Chairman PICKLE. They are going to put them into effect.

Mr. LOMAX. They are going to put them into effect in these particular areas.

Chairman PICKLE. What State is that?

Mr. LOMAX. May I refer that to Marty?

Mr. BLUM. I just want to state a guideline currently in effect in the State of New York for volume providers in that in a psychiatric examination, the interview must be one-half hour. The volume provider must interview and examine the claimant for one-half hour, and nonpsychiatric exam must be at least 20 minutes. That is the time the physician and the claimant are together, excluding laboratory time or history-taking by a nonprofessional.

That is currently in effect in the State of New York, and Mr. Lomax might have some other specifics.

Chairman PICKLE. Our committee will make inquiry with the various State agencies if these standards are proposed in the various States, which States have them, are they similar to what you are recommending, or are they going to put them into effect and when, and whether they would be State standards at this point.

The question is should we have State standards or Federal standards or a combination, but that is something that we will look at.

I thank both of you gentlemen for your testimony. Obviously, we will be in touch with you.

Our next witness was scheduled to be Dr. David B. Ketrosor, who is a physician from Hopkins, Minn., but his plane was grounded in Philadelphia and he may or may not be coming in by rail. We will have to skip his testimony at this point.

The next witness we will call is Mr. Martin Wegbreit, who is representing the Client Centered Legal Services of Southwest Virginia.

Is your name Mr. Wegbreit?

Mr. WEGBREIT. Wegbreit.

Chairman PICKLE. Mr. Wegbreit is staff attorney appearing here on behalf of Willie Allen Mullins, his client. I guess he is representing the Client Centered Legal Services of Southwest Virginia, Inc.

Mr. Wegbreit, we are glad to have your testimony. Would you please proceed.

STATEMENT OF MARTIN WEGBREIT, STAFF ATTORNEY, CLIENT CENTERED LEGAL SERVICES OF SOUTHWEST VIRGINIA, INC., ON BEHALF OF WILLIE ALLEN MULLINS, CASTLEWOOD, VA.

Mr. WEGBREIT. Good morning, Chairman Pickle. How are you feeling today?

Chairman PICKLE. I am not in a very good mood at this point. I hope I will feel better when you are finished, Mr. Wegbreit. [Laughter.]

Mr. WEGBREIT. All right. Your answer indicates you are cooperative, alert, and oriented, and in no acute distress. Your hearing and vision appear to be within normal limits. While sitting in the hear-

ing room, I have observed that you have no significant limitations in sitting, standing or walking.

Chairman PICKLE. Or talking. [Laughter.]

Mr. WEGBREIT. Or talking. I note that you have handled papers and written with a pen, showing both gross and fine motor dexterity. You are breathing normally and do not demonstrate apparent respiratory impairment.

You have just undergone about one-half of a consultative medical examination performed by a volume provider.

Chairman PICKLE. We had better correct the record. I have not poured myself any water, and I have not written with a pen. But I have been active in my chair. [Laughter]

Mr. WEGBREIT. And you were able to sit for at least an hour and a half, I noticed.

My name is Martin Wegbreit, and I am a staff attorney with Client Centered Legal Services of Southwest Virginia, Inc., of Castlewood, Va. I am speaking today on behalf of a client of mine, Willie Mullins, also of Castlewood, Va. I have been a Legal Services attorney for 3½ years, with one-quarter of my practice being in the social security and SSI disability field, handling over 100 such cases.

In my prefiled testimony I describe practices of three volume vendors. They produce reports of consultative medical examinations in the same manner as General Motors produces automobiles—by an assembly line. While this may produce good cars, it makes for poor medical examinations.

I would like to describe the impact of these practices upon individual clients, which can be and often is devastating. Time after time, the consultative examination reports are incomplete, inadequate, misleading, and confusing.

Bertie Bond, from Keokee, Va., was examined by Suburban Internal Medicine Group. Their report found she had a full range of motion in her back and walked with a mild right-sided limp. Ms. Bond went to the examining room with the aid of a walker. The SIMG report noted no significant pulmonary or ventilatory impairment.

The treating physician stated she was totally disabled due to severe chronic lung disease, fibrosis, and emphysema. She was awarded benefits by an administrative law judge 7½ months after she applied, a delay caused, in part, by the inaccurate SIMG report.

Horrow Willis, from Haysi, Va., was examined by Dr. James Eden, a volume provider of psychiatric examinations. Dr. Eden spent 5 minutes with him and concluded in the report that he was unable to substantiate a psychiatric diagnosis. Mr. Willis has been treated by a psychiatrist for 2½ years. He was denied benefits when the ALJ found he had no psychiatric impairment.

Shortly thereafter, Mr. Willis attempted suicide, but fortunately he did not succeed. His case is on appeal to Federal courts.

Pauline Rasnick, from Cedar Bluff, Va., was examined by an associate of Johnson and Byers in Bluefield, W. Va. The report stated that she had a full range of motion of the ankles, knees, hips, spine, shoulders, elbows, and wrists. A year before the examination Ms. Rasnick suffered a stroke which, according to her treating phy-

sician, left her with a complete left hemiparesis, or paralysis of the left side of her body.

After being initially denied on the basis of the Johnson and Byers report, Ms. Rasnick was found disabled by an ALJ in January 1982, a year after she applied.

Five Federal court decisions have held that the reports of Suburban Internal Medicine Group are deceptive and fraudulent and not substantial evidence upon which the Secretary can base his decision.

In view of this overwhelming judicial disapproval of consultative medical examination reports of Suburban Internal Medicine Group, the Social Security Administration should have expressed some concern. Instead, the reaction has been one of indifference and denial that a problem exists.

In my prefiled testimony I note that if a claimant appeals to the U.S. District Court and gets a remand, the Appeals Council will then exclude the SIMG report, but if a claimant seeks Appeals Council review from a previous administrative action, not only will the Appeals Council not exclude the SIMG report, but also if the SIMG report was previously excluded by an ALJ, the Appeals Council will reenter it into the record.

Now in response to this welter of contradictions and conflicts, two class-action lawsuits have been filed in the U.S. District Court for the Western District of Virginia. In the suits we seek injunctive, declaratory and mandamus relief and review of all decisions where a claimant for disability benefits was examined by SIMG and the case was denied.

We seek to enjoin the Social Security Administration from ordering consultative medical examinations by SIMG.

Chairman PICKLE. By whom? You recommend that they not have the examination by whom?

Mr. WEGBREIT. In the U.S. District Court we are suing and asking that the Social Security Administration be enjoined from scheduling consultative medical examinations by SIMG, enjoin the Social Security Administration from admitting the reports of those exams into the record, and denying claimant disability benefits based upon those reports.

In this suit we also seek to enjoin the Social Security Administration for failing to promulgate regulations governing the procedures to be used by physicians doing consultative examinations.

I would urge Congress to enact legislation which would require the Secretary of the Department of Human Services to promulgate regulations governing the procedures to be followed by physicians doing consultative medical examinations in connection with social security and SSI disability claims.

Examples of desirable regulations are in my prefiled testimony. I appreciate the opportunity to testify before the two subcommittees. I am hopeful that you will propose legislation incorporating some of the suggestions of claimants' representatives which you have heard and will hear today. As it was Congress who enacted the disability program, it would be most appropriate for Congress to regulate the abuses caused by consultative medical examinations.

One complaint raised recently against the Federal courts is the apparent tendency to legislate too much. While this tendency

exists, it is sometimes caused by the failure of the appropriate legislature to enact needed legislation.

In conclusion, the need is evident, and the solution is before you. I would like to leave with you the words of U.S. District Judge Glen Williams, who ruled on October 1, 1981, that the practices of the volume vendors were "an affront to the Government, to the courts, certainly to the claimant and ethical principles in general."

Thank you for your attention. I would request that my prefiled testimony be admitted into the record.

Chairman PICKLE. Your entire testimony will be included in the record.

[The prepared statement follows:]

STATEMENT OF MARTIN WEBBREIT, ESQ., CLIENT CENTERED LEGAL SERVICES OF
SOUTHWEST VIRGINIA, INC., ON BEHALF OF WILLIE ALLEN MULLINS

Good morning, Congressman, how are you feeling today?

Your answer indicates that you are cooperative, alert and oriented and in no acute distress. Your hearing and vision appear to be within normal limits. While sitting in the hearing room, I have observed that you have no significant limitations in sitting, standing or walking. I note that you have poured yourself a glass of water and written with a pen, showing both gross and fine motor dexterity. You are breathing normally and do not demonstrate apparent respiratory impairment.

You have just undergone about half of a consultative medical examination performed by a volume provider.

My name is Martin Wegbreit and I am a staff attorney with Client Centered Legal Services of Southwest Virginia, Inc. in Castlewood, Virginia. I am speaking today on behalf of a client of mine, Willie Mullins, also of Castlewood, Virginia. I have been a legal services attorney for three and a half years, with a quarter of my practice being in the Social Security and SSI disability field, handling over 100 such cases.

My opening description of a consultative medical examination is, unfortunately, not an exaggeration. I have read many reports of those examinations in which the physician made similar medical conclusions based upon similar brief observations. Were I a consultative physician, the remainder of the examination would consist of asking you to get up on the examining table, requesting that you move various parts of your body, and asking a few more questions. During the examination, I would probably not place my hands anywhere on your body nor use any kind of medical equipment on you, not even a stethoscope. Total time spent with you would be about five minutes.

Southwest Virginia, where I practice law, is a medically underserved area, with one physician for about every 1500 people. Many private physicians are unwilling or unable due to their busy schedules to perform consultative medical examinations. Some reliance upon volume vendors of these examinations may be necessary and even desirable. Reliance upon volume vendors whose practices are cursory, misleading and deceptive is not warranted or justified.

Practices of some volume vendors: As an example of some of these practices, I will describe the operation of Suburban Internal Medicine Group, also known as Thurman and Thurman and Associates. This is a professional corporation incorporated in Tennessee and doing business in Alabama, Georgia, Illinois, Indiana, Kentucky, Tennessee and Virginia. They produce reports of consultative medical examinations in the same manner as General Motors produces automobiles—by an assembly line. While this may produce good cars, it makes for poor medical examinations.

When the examinee enters the office, his background, medical and social history and current symptoms are noted by one non-medical person, his vital signs are taken by a second non-medical person, and he is then ushered into the examining room. The physician spends no more than five or ten minutes with him, in the manner described at the beginning of the testimony. The physician then dictates a few impressions, including how the physical capacities evaluation should be completed. The examination concludes with laboratory tests. Thirty-five such exams may be done each day.

If the examination occurred in Nashville, then the examining physician would write the report. If the exam were elsewhere, as is usually the case, this mass of random data is mailed to Nashville. There a physician who has never met the

claimant writes the report, fills out the physical capacities evaluation and signs the name of the examining physician to them. The examining physician never sees these documents, as they are mailed direct to the State Disability Determination Unit or the Social Security Administration.

While these practices are extreme, they are by no means unique to Suburban Internal Medicine Group. In my practice, it is more the rule rather than the exception to hear a Social Security or SSI disability client tell me that the consultative physician spent only five or ten minutes with him. Dr. James Eden, a psychiatrist at the Princeton Medical Arts Building, Princeton, West Virginia, typically spends five to ten minutes on a consultative exam and does not administer any psychiatric or psychological tests such as the Rorschach Test. A Pennsylvania corporation known as Johnson and Byers does consultative examinations in Bluefield, West Virginia, as well as locations in Michigan, Pennsylvania and other states. As with the Suburban Internal Medicine Group, the local office is open only a couple days each month, is staffed by aides who administer breathing tests and other complex procedures with only a minimum of training, and the physician spends only five or ten minutes with the examinee.

Impact upon individual clients: The impact of these practices upon individual clients can be, and often is, devastating. Applicants for Social Security and SSI disability benefits are unemployed, ailing, usually without any form of income, and often heavily in debt. Many times they have no treating physician, or their treating physician is unwilling to provide medical records due to unpaid bills for medical services. The report of the consultative physician is an important, and sometimes the only source of medical evidence of the claimant's disabilities.

Time after time, the consultative examination reports are incomplete, inadequate, misleading and confusing. When Willie Mullins was examined by Suburban Internal Medicine Group, the report misstated his age, education, work history, medical history, treatment history, medications, and height. Contrary to the statements in the report, the physician did not examine Mr. Mullins' head, eyes, ears, nose, throat, neck, abdomen, joints, back, ankles or feet; nor did the physician conduct a full range of motion study, muscular strength study, sensory study and two chest x-rays, as alleged in the report. His treating physician has written that Mr. Mullins has arteriosclerotic heart disease, angina and hypertension. Even though the SIMG report noted a blood pressure of 150/120, the report did not make a finding of heart disease or hypertension. Mr. Mullins' claim was denied on the basis of the SIMG report. He has appealed to Federal Court.

Bertie Bond from Keokee, Virginia was examined by SIMG, and their report found she had a full range of motion in her back and walked with a mild right sided limp. Ms. Bond went into the examining room with the aid of a walker, and her treating physician said that she had trochanteric bursitis, nerve root irritation and high lumbar disc. The SIMG report noted so significant pulmonary or ventilatory impairment. The treating physician stated she was totally disabled due to severe chronic lung disease, fibrosis and emphysema. She was awarded benefits by an Administrative Law Judge seven and a half months after she applied, a delay caused, in part, by the inaccurate SIMG report.

Rufus Bryant from St. Charles, Virginia was examined by SIMG and their report found that he had no critical degree of pulmonary impairment and an adequate range of motion in the spine. His treating physician said that he was totally and permanently disabled due to pulmonary fibrosis, emphysema and chronic lung disease with inactive tuberculosis. An orthopaedic surgeon stated that he had left sciatic nerve root irritation and advised Mr. Bryant to use a back support. Benefits were denied because of the ALJ's finding that the SIMG report was "a thorough clinical evaluation" which was "more persuasive as to the true ability of the claimant." Mr. Bryant gave up in hopelessness and did not appeal.

Violet Hartsock from Nicklesville, Virginia had been receiving disability benefits since 1974. In June of 1981 she was examined by SIMG as part of a continuing disability investigation. The report found that she had a adequate range of motion of the back and noted no problem with her abdomen or bowels. On the basis of that report, a month later she was terminated from benefits. She appealed and produced evidence from her treating physician that she was totally and permanently disabled due to an arthritic process involving the spine and scoliosis and due to a functional bowel syndrome. Last week, March 2, an Administrative Law Judge ruled in her favor. The SIMG report had kept her off benefits for seven months.

I could continue in this manner for some time, but the point has been made. Reports of Suburban Internal Medicine Group routinely find slight or no impairments in claimants whose treating physicians find severe and disabling impairments. Considering that the consultative physician spent five or ten minutes with the claimant

and then allowed another doctor to write the report, this should come as no surprise.

The reports of the other volume vendors mentioned also contain findings which are glaringly different from findings of treating and other physicians. Horrow Willis from Haysi, Virginia was examined by Dr. James Eden, a volume vendor of psychiatric consultative examinations. Dr. Eden spent five minutes with him and concluded in the report that he was unable to substantiate a psychiatric diagnosis. Mr. Willis has been treated by a psychiatrist for two and a half years and has been diagnosed as having depressive neurosis and free-floating anxiety, in spite of the psychotropic medication he has been prescribed. He was denied benefits when the ALJ found that he had no psychiatric impairment. Shortly thereafter, Mr. Willis attempted suicide, but fortunately, did not succeed. His case is on appeal to Federal Court.

Pauline Rasnick from Cedar Bluff, Virginia was examined by an associate of Johnson and Byers in Bluefield, West Virginia. The report stated that she had a full range of motion of the ankles, knees, hips, spine, shoulders, elbows and wrists. A year before the examination, Ms. Rasnick suffered from a stroke, which according to her treating physician left her with a complete left hemiparesis, or paralysis of the left side of her body. This treating physician, an orthopaedic surgeon found that she was totally and permanently disabled. After being initially denied on the basis of the Johnson and Byers report, Ms. Rasnick was found disabled by an Administrative Law Judge in January of 1982. Her case was so persuasive, the ALJ ruled for her at the hearing. She had been denied benefits for twelve months due to the inaccurate Johnson and Byers report, that is, from January, 1981, when she applied, until January, 1982, the date of the award.

Reaction of the Federal Courts: These matters were first brought to the attention of the Federal Courts on July 8, 1981 in the case of *Payne v. Schweiker*, Civil Action #80-0094-B (W.D. Va. Big Stone Gap Division), and six related cases. In these cases, U.S. District Court Judge Glen M. Williams ruled that:

"As to these cases presently before this court, the court finds from the evidence and the sworn deposition of Dr. Larry E. Martin that the reports, practices, medical procedures, methods and cursory medical examinations of Dr. Larry E. Martin, Drs. Thurman and Thurman and Suburban Medical Group are fraudulent in nature and the court so rules that such reports, practices, etc. are a fraud."

While the above ruling applied only to the cases then before the court, in the next case involving SIMG, Judge Williams did not so limit his ruling. In the case of *Bloomer v. Schweiker*, Civil Action #81-0153-B (W.D. Va. Big Stone Gap Division), and ten related cases, decided on October 1, 1981, the Court held that:

"A review of the records in these cases reveals that in denying benefits, the Secretary relied in substantial degree on consultative medical reports from Dr. Larry E. Martin. In earlier proceedings, manifested by order entered July 8, 1981, this court determined that the practices and procedures of Dr. Martin and his associates in producing such social security consultative reports are deceptive and fraudulent. Testimony from Dr. Martin established that in general practice, he would examine a claimant for a few minutes and then dictate a few cursory notes. Another doctor in the medical group, who had never seen the claimant, would then review the notes and produce a written report and physical capacities evaluation. The second doctor would then sign Dr. Martin's name to the report.

"Such practice is abominable. . . . The Secretary's reliance upon such fraudulent reports renders his final decisions meaningless."

Other Federal Courts have held that the reports of Suburban Internal Medicine Group are deceptive and fraudulent and are not substantial evidence upon which the Secretary can base his decision. These cases are: *Wood v. Secretary*, Civil Action #80-1506 (6th Cir. 10/23/81); *Collins v. Schweiker*, Civil Action #CIV-1-81-92 (E.D. Tenn. 10/23/81); and *Smith v. Schweiker*, Civil Action #C-81-0291-L(A) (W.D. Ky. 10/19/81).

In view of this overwhelming judicial disapproval of the consultative medical examination reports of Suburban Internal Medicine Group, the Social Security Administration should have expressed some concern. Instead, the reaction has been one of indifference and denial that a problem exists.

Reaction of the Appeals Council: The reaction of the Appeals Council to the SIMG reports has been two-faced, depending upon whether the case comes up to them on appeal or down to them on remand from the Federal Court. In the case of Willie Mullins, when I appealed to the Appeals Council, I included a four page memorandum supporting the striking of the SIMG report, along with Judge Williams' decision, Dr. Martin's deposition, and a transcript of the hearing. In response, the Appeals Council mailed a copy of the SIMG report to Dr. Martin and asked him to

personally sign it. When I objected that this did not cure the deceptive and fraudulent nature of the report, the Appeals Council relied upon the August 11, 1981 Social Security investigation which concluded that the reports of SIMG were acceptable. The Appeals Council did not mention, and totally ignored, Judge Williams' decisions.

The case of John Yates from Castlewood, Virginia, is even more egregious. Mr. Yates had been receiving disability benefits since 1971. He was examined by SIMG in September of 1979 as part of a continuing disability investigation. The report found no evidence of brain damage, even though disability benefits had initially been awarded for that impairment. Based on the SIMG report, benefits were terminated after December, 1979. At the hearing in August of 1981, claimant's representative objected to the SIMG report and it was stricken from the record. However, the Administrative Law Judge upheld the cessation. The case was appealed to the Appeals Council on the basis that the SIMG report was the only evidence that disability had ceased, and since that evidence had been stricken, there was no substantial evidence to support a cessation of benefits. Realizing the inadequacy of the record below, the Appeals Council re-entered the SIMG report into the record even though the ALJ had removed it. The case is pending before the Appeals Council but an affirmance of the cessation is predictable. Mr. Yates has been off disability benefits for 26 months on the basis of a report produced by methods which a Federal Judge has called fraudulent.

Yet, when the case comes down from Federal Court, the Appeals Council plays a different tune. In the case of Shirley Adams from Wise, Virginia, she was examined by Suburban Internal Medicine Group and denied benefits when their report was held as more consistent than the reports of the treating physician. An appeal was taken to Federal Court, *Adams v. Schweiker*, Civil Action #81-0149-B (W.D. Va. Big Stone Gap). The Secretary filed a Motion to Remand, which was approved by the Court on September 10, 1981. No mention was made in the remand order of the SIMG report. But when the case reached the Appeals Council, they ruled on November 30, 1981 as follows:

"The United States District Court for the Western District of Virginia has remanded this case (Civil Action #81-0149-B) to the Secretary of Health and Human Services for further administrative action.

"The Secretary had requested that the court remand this case in order to address certain questions that had been raised regarding the reports of Larry E. Martin, M.D. Based on the court's order of July 8, 1981 and October 1, 1981 on this issue, the Appeals Council hereby excludes from the record of the case the report of Dr. Martin dated April 26, 1980, as well as the document citing his professional qualifications."

Such double dealing should shock the conscience. It means that if a claimant appeals to the U.S. District Court and gets a remand, the Appeals Council will exclude the SIMG report. If a claimant seeks Appeals Council review from a previous administrative action, not only will the Appeals Council not exclude the SIMG report, but also if the SIMG report was previously excluded, it will be re-entered.

Reaction of the Administrative Law Judges: In the face of such contradictory signals from the Appeals Council, Administrative Law Judges have no clear guidance. As a result, they too are contradictory. When claimants are represented and a motion is made to exclude the SIMG report, generally the ALJ will exclude it. When claimants are unrepresented and no motion is made to exclude, then the report is kept in. Again, a double standard is present.

The volume vendor lawsuits: In response to this welter of contradictions and conflicts, two class action lawsuits have been filed in the U.S. District Court for the Western District of Virginia. One was filed by myself on January 6, 1982, styled *Mullins v. Schweiker*, Civil Action #82-0001-A. The other was filed by Joseph E. Wolfe, a private attorney in Norton, Virginia, on July 15, 1981 styled *Adams v. Schweiker*, Civil Action #81-0190-B. These actions were consolidated on January 25, 1982 and a class certification motion filed on February 4, 1982 is pending.

In the suits, we seek injunctive, declaratory and mandamus relief and review of all decisions where a claimant for disability benefits was examined by SIMG and the claim was denied. We seek to enjoin the Social Security Administration from scheduling consultative medical examinations by SIMG, admitting the reports of those exams into evidence, and denying claimants disability benefits based in part upon those reports. We also seek to enjoin the Social Security Administration from failing to promulgate regulations governing the procedures to be used by physicians doing consultative examinations. To phrase it in a more positive fashion, we want the Secretary to promulgate regulations.

Existing regulations, 20 C.F.R. 404.1517 and 416.917 permit the Social Security Administration to order that consultative medical examinations be performed on claimants for disability benefits. The regulations do not specify the procedures to be followed by physicians doing those examinations. This has led to the present problem.

Recommended Congressional action: I recognize that today the emphasis is upon fewer, rather than more, regulations, and to the extent that fewer regulations increase efficiency, save money and do not harm individuals, it is a trend that we can all wholeheartedly support. But in the present case, lack of regulations achieves none of these goals. It is inefficient to have to appeal Social Security and SSI disability cases to Federal Court in order to remove a deceptive and fraudulent consultative medical examination report from the record. It is costly for the Secretary to order a second consultative medical exam after the first has been stricken from the record. Most importantly, it harms individuals when they are denied or terminated from disability benefits on the basis of a deceptive and fraudulent report, and must wait six months, and sometimes years, to have the erroneous decision reversed.

In one sense, the controversy over volume providers of consultative medical examinations may be viewed as people "biting the hand that feeds them." After all, by paying for these exams, the government is trying to help people prove their cases for disability benefits, and these exams are not even required by the terms of the Social Security Act.

This argument falls of its own weight. As indicated by my earlier testimony, the exams are not helping people but harming them. While the exams are not mandated by statute, they do seem required under any elemental notion of fairness. The Social Security Administration stands in the relationship of a fiduciary to a claimant for disability benefits. During an individual's working years, the government has deducted FICA from his paycheck, conditioned on the promise that if he becomes disabled, it will pay him benefits. Because the government has this fiduciary duty to pay disability benefits, it has an obligation to assist in the presentation of a claim, just as any private insurance company would.

Accordingly, I would urge Congress to enact legislation which would require the Secretary of the Department of Health and Human Services to promulgate regulations governing the procedures to be followed by physicians doing consultative medical examinations in connection with Social Security and SSI disability claims. At a minimum, such regulations should include:

A limit on the number of examinations which may be scheduled per hour and per day; minimum competency requirements for technicians, aides and para-medics who assist in performing consultative exams; periodic checks on the equipment used in consultative exams; a requirement that the consultative physician personally author and sign the report and the physical capacities evaluation; a requirement that the State Disability Determination Unit consider paying for a consultative exam performed by the claimant's treating physician before considering a non-treating physician; a requirement that the State Disability Determination Unit establish contacts with community health clinics to get more consultative exams done locally instead of by volume vendors; require written documentation as to how much time the consultative physician spent examining the claimant; and, require written documentation that the laboratory tests and X-rays were actually done.

The question inevitably arises as to whether physicians would continue to perform consultative medical examinations should these types of regulations be enacted. Undoubtedly, some would not. It is my belief that most would. To the extent that promulgating regulations would save money due to more reliable exams resulting in fewer re-examinations, fewer erroneous decisions and fewer appeals, physicians could be paid as much, if not more, than they are presently receiving for consultative examinations. And to the extent that conscientious physicians already are voluntarily adopting the procedures suggested in the proposed regulations, their operating costs would not increase.

I appreciate the opportunity to testify before these two subcommittees and I am hopeful that you will propose legislation incorporating some of the suggestions of claimant's representatives which you have heard today. As it was Congress which enacted the disability program, it would be most appropriate for Congress to regulate the abuses caused by consultative medical examinations. One complaint voiced recently against the Federal Courts is their apparent tendency to legislate too much. While this tendency exists, it is sometimes caused by the failure of the appropriate legislature to enact needed legislation.

In the class action lawsuit I am litigating in Southwest Virginia, my co-counsel and I are requesting a Federal Judge to order the Secretary of Health and Human Services to promulgate regulations governing consultative medical examinations.

For Congress not to enact legislation requiring these regulations is to invite the Court to order them by judicial decree. Not only would it be more suitable for Congress to order the regulations, but also, quite frankly, my job as an attorney in the lawsuit would be made a whole lot easier.

In conclusion, the need is evident and the solution is before you. I would like to leave with you the words of U.S. District Court Judge Glen M. Williams, who ruled on October 1, 1981 that the practices of the volume vendor were "an affront to the government, to the court, certainly to the claimant, and to ethical principles in general."

Thank you for your attention.

Chairman PICKLE. I appreciate your testimony and your inquiry about my personal health and mental attitude. [Laughter.]

The conclusion of your testimony centers, I think, on a recommendation that you think the Secretary of HHS should promulgate regulations governing the procedures which physicians should follow in these consultative examinations.

I think you put your finger on a problem we face. We ought to have some standards. There ought to be some agreed procedure that is to be followed.

My question is: Do we do it on a Federal level, the Congress, the HHS; or do we do it at the State level or through medical profession itself?

In our disability bill last year, 2 years ago, we provided that the Secretary of HHS could establish these procedures, that he has the authority to do it. HHS has chosen not to do it, and instead has given that authority or left that authority to the State.

Now whether that is the proper direction for it to take, I do not know at this point. But that is how it is being handled.

As we proceed, though, I think we have to have a better determination that whoever is to do it, we have to have some procedures that are rather uniform and that are being carried out.

The examples you have stated, I assume, are factual situations, and you cannot question the inadequacy of what has taken place. I think your testimony gives added emphasis to the fact that either the HHS Secretary or the State agencies or the medical profession together or jointly have got to establish a more adequate procedure.

So I think you really go to the heart of the question, that we have got to do that.

Now I also think you raised a valid question at the end: If you did this, would this mean less number of physicians would participate in the examinations? Who knows that? I do not know how to answer that. Nobody does. You conclude that you think most of them would continue to do it, to do what we think is right in adopting the right procedure. We may have reached a point where eventually we will just have to make a determination to see if it will work.

Obviously, in certain areas, this is not being handled properly. We run into the inconsistency of the times by saying we are going to issue more rules and regulations at a time when everybody wants to cut them out. We have got to face that trend. Do we tighten it up, or do we kind of leave it up to the States? We do not know what to do.

That is why we are having these hearings, Mr. Wegbreit, to try to get the information. Your testimony has been very helpful, and I thank you.

Mr. Bailey, do you have any questions?

Mr. BAILEY. Yes, Mr. Chairman. Thank you.

Thank you very much for coming to testify.

You mentioned Johnson and Byers. You have had experiences apparently with different sources of consultative exams. Have you had experiences with different volume providers? And how do they differ from each other, if you have?

Mr. WEGBREIT. I have had experience with both Suburban Internal Medicine Group and Johnson and Byers. The main difference is that in the Suburban Internal Medicine practice, by and large, the reports are authored by a physician who has never seen the claimant. All the material is mailed to a central office, and the report is then authored. I do not believe that is the practice with Johnson and Byers.

Other than that, the procedures are very similar in terms of the very short amount of time, perhaps 10 minutes being spent by a physician with a claimant, the rest of the medical information being taken by relatively untrained personnel.

Mr. BAILEY. Have you had experience with additional volume providers than those two, that suburban group, so called, and Johnson and Byers?

Mr. WEGBREIT. As I mentioned in my testimony, there is a private psychiatrist who does a substantial number of consultative psychiatric examinations.

Mr. BAILEY. You would define him as a volume provider?

Mr. WEGBREIT. I do not know how many he does. I do know that I see an awful lot of claimants coming into my office who have been examined by the psychiatrist. I see so many that I can conclude that he does a substantial number of them.

Mr. BAILEY. Let me ask you this. Apparently then, the criticisms that you have and I think are presented to us from a number of places and sources across the country now, those criticisms, you feel, are characteristic of volume providers in general then?

Mr. WEGBREIT. By and large, yes. The main criticism being the very short amount of time being spent by the physician with the claimant and the fact that the supporting medical data is taken by relatively untrained medical personnel on equipment whose reliability is completely unknown.

Now the Suburban Internal Medicine Group practices are even more egregious by having the reports authored by another physician.

Mr. BAILEY. You heard the recommendation earlier that volume providers, send the results of their CE's to the original treating physician. Would you share with us your remarks and reflections? Would you share that recommendation?

Mr. WEGBREIT. I would agree with the recommendation, but I do not think that it will be as successful as might be imagined. In general, it is sometimes as difficult as pulling hen's teeth to get anything from a treating physician, simply because the treating physicians are so overworked.

I am in an area that is medically underserved. There is 1 doctor for about every 1,500 people, and the treating physicians just do not have the time to respond to my inquiries, let alone social security's.

Mr. BAILEY. What is your solution? What is your recommendation, if you have one?

Mr. WEGBREIT. The recommendations I have in my testimony are: To promulgate the regulations, placing limits such as the limit on the total number of exams that can be done per day, per hour.

Mr. BAILEY. We are very short on time. Forgive me for interrupting you from time to time.

We had a recommendation from some folks who just preceded you about some of New York's rules. New York apparently requires a 20-minute meeting with the physician, whether the physician likes it or not, I guess, with the claimant; and an hour for psychiatric consultation. Do you think some kind of qualifying limit of that sort can be helpful?

Mr. WEGBREIT. I believe the New York rule is one-half hour for a psychiatrist. But I think both are too short. I think at least an hour for psychiatric, to 45 minutes for others.

Mr. BAILEY. You would like to see a specific time, quantity of time to cut down on the number of examinations per day?

Mr. WEGBREIT. Yes.

Mr. BAILEY. And perhaps force that physician to talk with the patient?

Mr. WEGBREIT. Yes, I would support that type of a regulation.

Mr. BAILEY. I believe I have a little time left that I will yield back to the Chair.

Chairman PICKLE. Thank you, Mr. Bailey.

Mr. Wegbreit, we raised this question with a representative of the Social Security Administration in testimony before the committee previously with respect to the issuance or the establishment of some regulation or formal standards. This was the reply the SSA official gave to us, in part. I quote:

We do not—this is SSA speaking—We do not believe the performance of consulting physicians requires regulations by us. Our experience clearly indicates that overall the State agencies are maintaining effective relationships with the State medical community. We have been getting objective evaluations from consulting physicians. Further, State agencies overall are effectively monitoring the quality of the consultative examinations purchased by them. If commenters have evidence of improper medical consultative practices, they should submit this evidence to the State agency.

Do you think the State agencies Mr. Wegbreit, are properly monitoring these examinations?

Mr. WEGBREIT. Chairman Pickle, if what the State agencies are saying is true, I would not have about six or eight examples of clearly improper procedures and clearly erroneous results in my prefiled testimony. I did not have to look very hard for these either. It took me about a half a day to find these examples, and I could find plenty more. I do not think they are monitoring them properly.

Chairman PICKLE. Do you think the State agencies are properly monitoring these examinations?

Mr. WEGBREIT. Not only do I not think they are not properly monitoring, but I think the entire process is one of a whitewash and a coverup.

Chairman PICKLE. They have invited your comments. Have you commented to the social security people in your area, in your city, or to the HHS here?

Mr. WEGBREIT. When I appealed Willie Mullins case to the appeals council which decides upon these claims, I requested that they exclude the Suburban Internal Medicine Group report. I submitted a four-page memorandum. I submitted a copy of Judge Williams' decision which called the report "fraudulent." I submitted a copy of the deposition of Dr. Martin, who testified that he spent 5 minutes.

In response, the appeals council sent the report to Dr. Martin and said, please sign it. It had been 7 months since Dr. Martin had written that report. He signed it and sent it back. The appeals council denied. I am in Federal court.

Mr. Yates from Castlewood, Virginia, when his case came up, we moved to strike the Suburban Internal Medicine Group report at the administrative judge level. The administrative law judge struck it from the record but moved against Mr. Yates anyway. We appealed to the appeals council and the appeals council put the report back in.

They are saying, you can comment on the report. That indicates that they have no desire whatever to clean house. The appeals council will not clean house.

And if the appeals council, which is the top administrative body of the social security in terms of decisionmaking, will not clean house, the ALJs will not do it, the disability determination units will not do it, the district offices will not do it, then somebody has got to tell them to do it.

Chairman PICKLE. I am going to ask the subcommittee staff to make contact with the proper SSA officers in the Virginia area to which the witness has made reference and get their reaction to this testimony.

I thank you very much, Mr. Wegbreit, for your testimony.

The next witnesses will be Mr. John Vail and Mr. Paul Drozdowski.

Mr. BAILEY. If the Chairman would yield, we have to take the Chairman back to Pennsylvania to teach him to pronounce some of those Slovakian, Polish, and Ukrainian names.

Mr. DROZDOWSKI. He said it pretty well, though.

Chairman PICKLE. Off the record.

[Discussion off the record.]

Chairman PICKLE. Mr. Vail is the Litigation Director of the Legal Services of Upper East Tennessee, and Mr. Drozdowski is a representative of a paralegal group of the Rural Legal Services of Tennessee. Which one of you gentlemen wishes to present your testimony?

Mr. DROZDOWSKI. Congressman, I am going to go first. I am Paul Drozdowski.

Chairman PICKLE. All right.

Mr. DROZDOWSKI. Then Mr. Vail will go, and then we will be glad to entertain any questions you might have.

Chairman PICKLE. That will be fine. Mr. Drozdowski, you may proceed.

**STATEMENT OF PAUL E. DROZDOWSKI, PARALEGAL, RURAL
LEGAL SERVICES OF TENNESSEE, INC.**

Mr. DROZDOWSKI. My name is Paul Drozdowski. I am a paralegal at Rural Legal Services of Tennessee in Cookville, Tennessee. I appreciate the opportunity to come here and speak to you today regarding the problem with volume providers of consultative examinations.

I have been a paralegal for about 6 years, working both in Tennessee and in Massachusetts. Since I first came to Tennessee in the summer of 1980, I have had the opportunity to review several hundred cases, which include Thurman and Thurman examinations. There have also been numerous discussions among legal services groups about this problem.

We are concerned about this particular volume provider because we feel that they often perform superficial examinations, generate impressive reports prepared on advanced word processing equipment, the substance of which has come primarily from assistants. When you compare some of these reports of the examinations, whole sections can be removed from one and put in another report.

The problems I point out to you are not with one particular physician affiliated with the group, but with several different ones. There are complaints that results of tests and studies are reported which have not actually been performed. There have been complaints about the manner in which particular tests have been administered, and tests that should have been administered were not. There are inconsistent measurements of height and weight. There are reports where patients' sex or race have been incorrectly listed. Obvious medical problems are overlooked. And these problems are easily possible when the physician who examines a patient does not then sign the report.

The general feeling of those who have been examined by this particular medical group is, they have been run through the mill.

There are three basic questions that are raised by the cases I will describe to you and which—I think the questions have already come up here. Are the taxpayers in the Social Security Administration getting what they paid for? Is it fair to the claimants for the Social Security Administration to rely on these type of reports? And what can be done to correct the problems?

Attached to my written testimony there were seven affidavits from clients, also with attached copies of some of the reports from the Thurmans. I would just like to highlight a couple of those affidavits.

James E. Redmon was seen by Dr. Thurman on February 26, 1981. He was first seen by an aide, who asked him some questions about his medical history, weighed him, and had him do some breathing tests. Mr. Redmon has problems with his left foot and leg, breathing problems, arthritis, back problems, and deafness. He was with Dr. Thurman for a total of about 10 minutes. When Dr. Thurman came into the room, he looked at Mr. Redmon's left knee but did not have him remove his sock from his left foot to examine

it. He had Mr. Redmon walk back and forth, sit on the table, and manipulate his left leg until it hurt Mr. Redmon.

The Thurman report of the examination said that Mr. Redmon was only having pain in his back and not taking any medications. Mr. Redmon was in fact taking medication for arthritis and for breathing problems. He was never asked any questions about back pains or breathing problems, nor whether he was taking medication. Mr. Redmon did not remember Dr. Thurman doing any of the range-of-motion tests which were reported. Dr. Thurman's report also noted that the patient could hear without any problems up to 6 feet. No scientific testing was done of his hearing.

Mr. Redmon remembered Dr. Thurman only speaking to him once during the examination. That was when he was standing right next to him. In the report, Dr. Thurman also talked about how the left foot looked, but he never saw it without the sock being removed.

In December 1981, Mr. Redmon was sent to another consultative examination by social security. In this consultative examination, the doctor spent over 3½ hours with him, and also asked other doctors to come in and consult and look at the problems with his foot.

Ina L. Burton is a licensed practical nurse. She was examined by the Thurmans on January 13, 1981. As an LPN, Mrs. Burton has assisted doctors in doing examinations of patients. She has worked in a hospital nursery, X-ray room, and emergency room. She is familiar with medical terms and procedures. Mrs. Burton has a number of medical problems. She has a peptic ulcer, duodenal ulcer, and a chronic ulcer crater in her stomach. She is almost deaf in her right ear and has a disorder of the meniscus part of her face. She has osteoarthritis, congestive heart failure, diabetes, bronchitis, a bad shoulder, and a deformity in her feet.

When she got to the examination, she was first interviewed by an aide who checked her height, weight, and got a brief history. She was then sent into an examining room, and Dr. Thurman came in. He did a brief examination, checking her heart and breathing. He briefly looked into her ear and did notice the fact that she had an infection. He spent a total of about 3 or 4 minutes with her. The assistant did the rest of the examination, including an X-ray and a breathing test.

During the breathing test, Mrs. Burton felt that she was put under unnecessary pressure by the assistant hollering and snapping her fingers, ordering her to breathe harder and harder during the test. When Mrs. Burton saw the report of the examination, she was rather surprised. The report incorrectly listed her height. The report noted that "the patient comes in mostly because of ear problems." Dr. Thurman noted that the patient had no trouble hearing spoken conversation at 6 feet. Mrs. Burton in fact has a 70 decibel hearing loss in her right ear and an obvious deformity in and around her right ear which was not noted, and no scientific testing was done of her hearing.

Dr. Thurman's report also failed to note an obvious deformity in Mrs. Burton's feet. The report also noted there were no problems with ulcers when, in fact, she has three kinds of ulcers. Mrs. Burton was also surprised to see a report of the range-of-motion study. She was quite positive that they were not done in the office

the day of her examination. She felt her examination was far from complete.

I would just like to give one more example here. J. D. Burns was examined by Steven Thurman on March 30, 1981. Since the spring of 1979, Mr. Burns has been unable to work due to a recurrent retroperitoneal cyst—excuse me, abscess in the right flank of his lower back, which was dressed and draining on the date of the consultative examination. Mr. Burns asked Dr. Thurman to call his treating physician before removing the dressing and examining the abscess, but Dr. Thurman refused, saying that he was a doctor and he knew what he was doing. Mr. Burns' treating physician normally gave him a pain killer prior to even examining this abscess.

Dr. Thurman then removed the dressing and probed the abscess with a cotton swab, which caused great pain to Mr. Burns. Dr. Thurman then refused to dress the wound or replace the drainage tubes. Mr. Burns' wife had to dress the wound and replace the drainage tubes after the examination.

I think these affidavits point out some serious problems with this particular high-volume provider. The problems are cursory examinations, failure to perform tests which are indicated, reports of test results that were not administered, questionable procedures, and qualification of assistants in administering tests, inaccurate and incomplete information in the report, and questionable treatment of the patients themselves.

If the same type of examinations were done by a doctor who did only two consultative examinations a year for the Social Security Administration, it was two too many. Because they are done by volume providers, the problems here are greatly magnified. Now, Mr. Vail will discuss this matter a little further and make some recommendations.

[The prepared statement and additional material follow:]

STATEMENT OF PAUL E. DROZDOWSKI, PARALEGAL, RURAL LEGAL SERVICES OF
TENNESSEE, INC.

Thank you for the invitation and the opportunity to discuss with you the use of volume providers of consultative examinations in the Social Security disability programs. I am here with John Vail, an attorney at Legal Services of Upper East Tennessee representing clients of the Legal Services programs in Tennessee who have been examined by the Suburban Internal Medical Group, i.e., Thurman & Thurman, a volume provider. As a paralegal with Rural Legal Services of Tennessee in Cookeville, I review almost 200 Social Security disability cases a year and have had the opportunity to review many of the reports of examinations done by Suburban Internal Medical Group. Since I first came to Tennessee in the summer of 1980, I have investigated numerous complaints and represented clients who have been examined by employees of this medical group and whose disability benefits have been either terminated or denied as a result of these examinations.

We are concerned that the volume providers often performed superficial examinations, and then generate impressive looking reports prepared on advanced word processing equipment, the substance of which has come primarily from medical assistants. A close review of the reports reveals that whole sections of the reports can practically be substituted for corresponding sections applicable to other patients.

The problems I will point out to you are not with one particular physician affiliated with the group, but with several different ones.

There are complaints that results of tests and studies which have not actually been performed on the patients are included in the reports. There have been complaints about the manner in which particular tests were administered and that tests which should have been administered, were not. There are inconsistent measurements of height and weight. There are reports where the patient's sex or race have been incorrectly listed. Obvious medical problems are overlooked. These prob-

lems are easily possible when the physician who examines a patient does not sign the report. The general feeling of those who have been examined by this group is that they have been "run through the mill."

Suburban Internal Medical Group at one time employed twelve (12) physicians and had offices in four (4) Tennessee cities. They performed 31.9 percent of the consultative examinations ordered by the state agency last year in Tennessee and they received \$827,000 for those consultative examinations. We also understand that this group, at various times, has had offices and performed examinations in five (5) other states.

By their own admission (Deposition of Larry Martin, M.D., 3/25/81) this group was performing between 25 and 35 examinations per day with an average of 30 per day. The resulting reports were routinely signed by a physician other than the one who actually saw the patient. The treating physician never actually viewed the report before it was sent to the State Agency.

Three basic questions are raised by the cases I will describe to you:

(1) Are the Social Security Administration and taxpayers getting what they pay for?

(2) Is it fair to the claimant for the Social Security Administration to rely on these reports?

(3) What should be done to correct the problems?

Attached to this testimony are a number of affidavits from clients in Tennessee who have been examined by this medical group. I would like to go into some of the specific examples of what actually happened during the examinations.

Mr. Ray Ogg (Exhibit 1) was examined by Dr. Grafton Thurman on January 30, 1980. The entire examination took about thirty (30) minutes, only ten (10) minutes of which was with the doctor. A woman who did not identify herself but appeared to be an assistant asked him what was wrong with him. He did not remember her asking any other background questions. An EKG, chest x-ray, and breathing test were administered by the assistant. He did not remember anyone measuring his weight, height, or his blood pressure. He did not remember the doctor looking at his throat, neck or chest, or asking him to bend over or move his arms, back or legs. The report of this examination gave the patient's height and weight, blood pressure, and range of motion. With reference to his eyes, Dr. Thurman's report stated that his eyes were free of hemorrhage. Only three months later another examination stated that Mr. Ogg had "cataracts in both eyes, retinopathy in both eyes, and scattered exudates and hemorrhages in both eyes." Mr. Ogg says that Dr. Thurman did not even look at his eyes at all. Mr. Ogg was left with the feeling that he had not really been examined. He said that it seemed like the doctor just wanted to get him in and out of there as quickly as possible.

Walter B. Ingram (Exhibit 2) had an examination with Dr. Stephen Thurman in January, 1978. Mr. Ingram's treating physician had diagnosed that he had advanced emphysema. Dr. Thurman never diagnosed the emphysema. Mr. Ingram also noted that he was in the office a total of about one-half hour with the majority of time being spent with an assistant who took an x-ray and gave him the breathing test. He was with the doctor, at most, five (5) minutes. Mr. Ingram did not remember Dr. Thurman or his assistant examining his neck, abdomen, extremities, reflexes, or giving a range of motion test. The report of Mr. Ingram's examination reflected findings in all of these areas.

James Carney (Exhibit 3) was examined by Dr. Stephen Thurman on October 16, 1979, and again on April 16, 1980. Each time the examinations consisted primarily of tests administered by Dr. Thurman's assistants. Mr. Carney said he spent about five (5) minutes with Dr. Thurman at each examination. When Dr. Thurman examined Mr. Carney in October of 1979 he described him as being 64½ inches tall and a weight of 103 pounds. He was described as a "small, well developed gentleman." In the April report Mr. Carney was described as being 62¾ inches tall and described as a "well developed, well nourished gentleman." Mr. Carney is, in fact, 66 inches tall, has severe nutritional problems, and obstructive pulmonary disease.

Mr. Carney was later examined by Dr. James P. Wilson in another consultative examination. Dr. Wilson's examination lasted approximately an hour and a half. The pulmonary function study report submitted by Dr. Wilson correctly listed his height as 66 inches and weight as 98 pounds. Dr. Wilson described him as a "somewhat wasted white male." In a case like this the height of an individual is most important in determining the pulmonary functional capacity.

William L. Newland (Exhibit 4) was examined by the Suburban Internal Medical Group in April, 1979, by Dr. Peter Thurman, and in June, 1979, by Dr. Stephen Thurman. Mr. Newland recalled that both the April and June examinations consisted mainly of tests done by one of Dr. Thurman's assistants. The assistant did the

chest x-ray, administered the breathing test, and took the blood sample. He remembered the April examination lasting about two (2) or three (3) minutes. He said the doctor only looked at the x-rays and listened to his back with a stethoscope. During the June examination, the assistant who was taking a blood sample had difficulty getting the needle into the vein. He said she had to do it several times and finally another assistant came and did it. The examination in June consisted of Dr. Thurman hitting his leg with a hammer and telling him to lift his arms above his head. He did not look into his eyes, ears, or nose. Lengthy reports resulted from these cursory examinations.

James E. Redmon (Exhibit 5) was sent to see Dr. Thurman on February 26, 1981. He was first seen by an aide who asked him some questions about his medical history, weighed him and had him do some breathing tests. Mr. Redmon has a problem with his left foot and leg, breathing problems, arthritis, back problems, and deafness. He was with Dr. Thurman for a total of about ten (10) minutes. When Dr. Thurman came into the room he looked at Mr. Redmon's left knee but did not have him remove his sock from his left foot. He had Mr. Redmon walk back and forth, had him sit on the table and manipulated his leg until it hurt.

The Thurman report of the examination says that Mr. Redmon was only having pain in his back and not taking any medications. Mr. Redmon was, in fact, taking medication for arthritis and for breathing problems. He was never asked any questions about back pains or breathing problems, nor if he was taking any medicine. Mr. Redmon did not remember Dr. Thurman doing any of the range of motion tests which were reported. Dr. Thurman's report noted that the patient could hear without any problems up to six (6) feet. No scientific testing was done of his hearing. Mr. Redmon remembered Dr. Thurman only speaking to him once during the examination and that was when he was standing right next to him. In the report, Dr. Thurman also talked about how the left foot looked, even though he never saw it without the sock. In December, 1981, Mr. Redmon was sent to another examination by Social Security. In this consultative examination the doctor spent over three and one-half hours with him and also asked some other doctors to come in to look at his foot.

Ina L. Burton (Exhibit 6) is a licensed practical nurse. She was examined by the Thurmans on January 15, 1981. As an LPN, Mrs. Burton has assisted doctors in doing examinations of patients. She has worked in a hospital nursery, x-ray room, and emergency room. She is familiar with medical terms and procedures. Mrs. Burton has a number of medical problems. She has a peptic ulcer, duodenal ulcer, and a chronic ulcer crater in her stomach. She is almost deaf in her right ear and has a disorder of the meniscus, in her face. She has osteoarthritis, congestive heart failure, diabetes, bronchitis, a bad shoulder and a deformity in her feet. When she got to the examination she was first interviewed by a nurse or an aide, who checked her height, weight, and got a brief history. She was then sent into an examining room and Dr. Thurman came in. He did a brief examination, checking her heart and breathing. He briefly looked into her ear and didn't notice the infection in her ear. He spent a total of about three (3) or four (4) minutes with her. The assistant did the rest of the examination, including an x-ray of the chest and shoulder and a breathing test. Mrs. Burton felt she was put under unnecessary pressure by the assistant's hollering and snapping her fingers ordering her to breath harder and harder during the breathing test.

When Mrs. Burton saw the report of the examination she was rather surprised. The report incorrectly listed her height. The report noted that "the patient comes in mostly because of ear problems." Dr. Thurman noted that the patient had no trouble hearing spoken conversation at six (6) feet. Mrs. Burton has a 70 decibel hearing loss in her right ear and an obvious deformity in and around her right ear which was not noted by Dr. Thurman. No scientific testing of her hearing was done. She also has an obvious deformity in her feet which was not noted in Dr. Thurman's report. Dr. Thurman's report also noted that she had no problems with ulcers, when, in fact, she has three kinds of ulcers. Mrs. Burton was also surprised to see the reports of range of motion studies. She was positive that they were not done in the office the day of her examination. Mrs. Burton felt her examination was far from complete.

J. D. Burns (Exhibit 7) was examined by Stephen Thurman on March 30, 1981. Since the spring of 1979, Mr. Burns has been unable to work due to a recurrent retroperitoneal abscess in the right flank of his lower back which was dressed and drained on the date of the consultative examination. Mr. Burns asked Dr. Thurman to call his treating physician before removing the dressing and examining the abscess, but Dr. Thurman refused Mr. Burns' treating physician normally gave him a pain killer prior to examining the abscess. Dr. Thurman removed the dressing and probed the abscess with a cotton swab which caused great pain to Mr. Burns. Dr.

Thurman then refused to dress the wound or replace the drainage tubes. Mr. Burns' wife had to dress the wound and replace the drainage tubes. Mr. Burns says that his height, weight, and blood pressure were not measured and that x-rays, EKG's and breathing tests were not done.

I believe that these affidavits point out some serious problems with this particular high volume consultative provider. The problems are:

1. Cursory examinations.
2. Failure to perform tests which are indicated.
3. Reporting of test results which were not administered.
4. Questionable procedures and qualifications of assistants administering tests.
5. Inaccurate and incomplete information in the reports.
6. Questionable treatment of patients.

If the same type of examinations were done by a doctor who did only two consultative examinations a year for the Social Security Administration, it was two too many.

I firmly believe that the Social Security Administration is not getting what it pays for and the reliance on these reports as a reason for denial is an injustice to applicants and recipients of disability benefits.

In his testimony before this committee, Herbert Brown, Director of the Disability Determination Section in Tennessee said that "The DDS must guard against the physician who, trying to respond to the needs of the agency, becomes overzealous, spends too little time with the patient and submits reports not accurately reflecting the patient's condition." I agree with Mr. Brown's statement. I would say that we are faced with the very problems he notes. The Social Security Administration and the State Agency must have some kind of a system to make sure that they are getting what they pay for in these consultative examinations.

Mr. Vail will now discuss this matter further and make some recommendations.

LIST OF EXHIBITS

Exhibit 1.—Affidavit of Ray Ogg.

Exhibit 2.—Affidavit of Walter B. Ingram.

Exhibit 3.—Affidavit of James Carney and Medical Reports by Dr. Stephen Thurman, October 16, 1979 and April 16, 1980.

Exhibit 4.—Affidavit of William L. Newland and Medical Reports of Drs. Peter and Stephen Thurman, April 7, 1979 and July 13, 1979.

Exhibit 5.—Affidavit of James E. Redmon.

Exhibit 6.—Declaration of Ina L. Burton and attached Medical Report of Dr. Grafton Thurman, January 17, 1981.

Exhibit 7.—Affidavit of J. D. Burns and Attached Medical Report of Dr. Stephen Thurman, March 31, 1981.

STATE OF TENNESSEE)
) ss.
COUNTY OF DAVIDSON)

I, RAY OGG, after being first duly sworn, state as follows: .

I was sent on January 30, 1980, by the SSA for an examination by a Dr. Grafton Thurman. I reported for the exam, and briefly saw someone; however, I cannot be sure who this was as the man did not identify himself. He was short, with a slightly chunky build.

I was with the doctor for only about ten minutes. The entire exam took about thirty minutes.

A woman who did not identify herself but appeared to be an assistant asked me what was wrong with me. This was all she asked. She did not ask any other background questions on my past medical history.

I was then told to take off my shirt and an EKG was administered by the woman assistant. After the EKG, I was told I could put my shirt back on. I was never undressed at all for any other part of the exam.

I was also given a chest x-ray and a breathing test. Both of these were done by the assistant. On the breathing test, I took two breaths and breathed into a machine. Then the assistant sprayed a broncho-dilator in my mouth and I took two more breaths and breathed into the machine. I have had breathing tests before and I usually have to breathe into the machine many more times than this test. This breathing test did not seem as thorough to me as the ones I have had in the past.

Exhibit 1

After these tests, the doctor came into to look at the x-ray. This was the first time I had seen him. I was fully clothed at the time and he did not examine me at all. He then looked at the x-ray and said to me "You have bad emphysema. I am going to help you get your Social Security but if you don't quit smoking, it won't do you any good."

No one took my height or weight, or my blood pressure. The doctor did not look down my throat, examine my neck, or listen to my chest with a stethoscope. He did not examine my abdomen, or test my reflexes. He did not look into my eyes, or examine my feet, arms or legs. He did not ask me to bend over or move my back, arms or legs. Neither the doctor nor his assistant gave me any kind of actual examination. I was given the chest x-ray, the EKG, and the breathing test by the assistant and this is all that was done. The doctor himself never examined me at all. He only looked at the chest x-ray in front of me.

It is my understanding that in the report of this exam, there is data on my height and weight, blood pressure in both arms, eyes, mouth, neck, lungs, abdomen, reflexes, extremities, and range of motion tests. No one ever examined me for these things. I also understand that Dr. Thurman's report states about my eyes: "The conjunctive are noninflamed and the scleral are clear. Retinae are free of hemorrhages and exudates."

Only three months later, another consultative exam, an ophthalmology report, stated I have "cataracts in both eyes,

retinopathy in both eyes, and scattered exudates and hemorrhages in both eyes." Dr. Thurman did not look in my eyes at all, just as he did not examine me in any other way. I have had a physical exam before and this exam was not at all like most exams I have had in the past.

As I left, I told my sister, Mrs. Hyde, that I didn't feel like I had really been examined. I felt that they just wanted to get me in and out as quickly as possible. This is an accurate account to the best of my recollection, knowledge and belief.

FURTHER AFFIANT SAITH NOT.

RAY OGG

Sworn to and subscribed before me this 9th day of February, 1982.

Judith C. Pickenill
NOTARY PUBLIC

My commission expires: April 17, 1983

STATE OF TENNESSEE)
) ss.
COUNTY OF DAVIDSON)

I, WALTER B. INGRAM, after being first duly sworn, state as follows:

In January, 1978, I was told by the Social Security Administration to go for a consultative examination to Dr. Stephen Thurman.

I reported for the exam, although I had a severe case of the flu at that time, and even had to be driven to his office as I was too sick to drive myself. I was terribly congested in my head and chest. Besides having the flu at the time, I have a diagnosis of advanced emphysema. Dr. Larry Grossman is my treating physician who made this diagnosis. Another doctor, Dr. McCracken, also has treated me. Both Dr. Grossman and Dr. McCracken felt I was disabled from my emphysema. Dr. Thurman's report stated my chest x-ray was normal and my lungs were basically clear, and that my chest had "excellent breath sounds." He also never diagnosed me as having emphysema. Having advanced emphysema and the flu at the time of the exam, I wondered how Dr. Thurman could overlook this so completely and why his opinion differed so widely from my own doctors'.

I was in the office a total of about one-half hour, and the majority of the time was spent with a technician who took a chest x-ray and gave me a breathing test. I was only with Dr. Thurman, at the most, five minutes. I was shocked at the

Exhibit 2

brevity and casualness of his exam. All he did was look down my throat, listen to my chest with a stethoscope, and look in my ears and eyes.

At no time did Dr. Thurman or his assistant examine my neck, abdomen, extremities, reflexes, or give me a range of motion test. It is my understanding his report reflected data on all these areas.

I also understand Dr. Thurman commented several times on my exercise tolerance around the officing, stating "He is able to exercise around the office without any trouble whatsoever." I am wondering just what this meant, as all I was asked to do was to walk into the room and get up on the examining table.

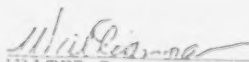
After the Thurman examination, I also went to Veteran's Hospital, where I was put through about three days of exhaustive tests and examinations. They also agreed with Dr. Grossman and Dr. McCracken that I was totally disabled due to chronic obstructive pulmonary disease and I was awarded total non-service connected disability. As far as I am aware, Dr. Thurman's report was contradicted by all other medical opinions.

I was also later awarded Social Security disability; however, from the time I filed the claim until it was awarded, it took almost three years, went all the way to federal court, and cost me \$5,000.00 in attorney's fees.

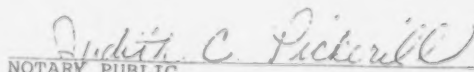
I felt that the exam I was given by Dr. Thurman was grossly inadequate. It was amazing to me that after so brief an exam, he could dictate such a lengthy, detailed report and make any findings as to my disability.

This account is correct to the best of my recollection, knowledge and belief.

FURTHER AFFIANT SAITH NOT.


WALTER B. INGRAM

Sworn to and subscribed before me this 15th day of February, 1982.


NOTARY PUBLIC

My commission expires: Feb 12, 1983

ST. THOMAS MEDICAL BUILDING
4230 HARDING RD-4TH FLOOR
NASHVILLE, TENNESSEE 37203

Laurence A. Grossman, M.D.
Cardiovascular Disease
Alan L. Greber, M.D., P.C.
Endocrinology
James P. Gregory, M.D., P.C.
Internal Medicine
K. M. Rejo, M.D.
Internal Medicine
James P. Wilson, M.D.
Hypertension
Internal Medicine

April 12, 1978

PRACTICE LIMITED TO
INTERNAL MEDICINE

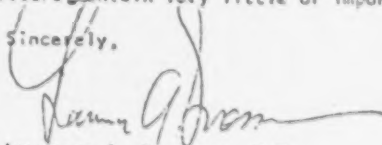
Mr. Walter Ingram
Nashville,
Tennessee

Dear Walter:

Enclosed are prescriptions for Hycomine, Dalmane and Tuinal. You can try one or the other and see if it works better.

I'm sorry that you have had so much trouble with your Social Security. I do not think Dr. Thurman is capable of judging whether you can work. I hope the decision will be in your favor; you certainly have advanced emphysema. Most long-winded letters contain very little of importance.

Sincerely,



Laurence A. Grossman, M.D.

LAG v

ST. THOMAS MEDICAL GROUP
4230 HARDING RD. SUITE 400
ST. THOMAS MEDICAL BUILDING
NASHVILLE, TENNESSEE 37205

Laurence A. Grossman, MD
Cardiovascular Disease
Alan L. Graber, MD, PC
Endocrinology
James P. Gregory, MD, PC
Internal Medicine
R. M. Raja, MD
Internal Medicine

PRACTICE LIMITED TO
INTERNAL MEDICINE

January 29, 1982

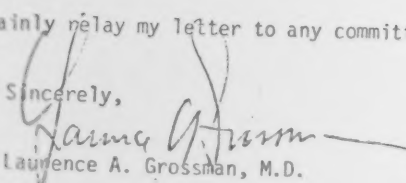
James P. Wilson, MD, PC
Hypertension
Internal Medicine
Antonio M. Granda, MD, PC
Gastroenterology
Internal Medicine
A. Clyde Helin, Jr., MD
Pulmonary Medicine
Internal Medicine

Mr. Peter Komlos-Hrobsky
Staff Attorney
Tennessee Association of Legal Services
1518 Parkway Towers
404 James Robertson Parkway
Nashville, Tennessee 37219

Dear Mr. Komlos-Hrobsky:

You can certainly relay my letter to any committee
or to any group.

Sincerely,


Laurence A. Grossman, M.D.

LAG:js

RECEIVED

FEB 17 1982

RLST

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AFFIDAVIT

STATE OF TENNESSEE)

COUNTY OF SUMNER)

JAMES CARNEY, being duly sworn, deposes and says:

1. I am 55 years old and reside at Route 5, Box 392, Lebanon, Tennessee 37087.
2. I was examined by Dr. Stephen Thurman twice - on October 16, 1979, and again on April 16, 1980, in connection with my application for disability benefits. Each time the examination consisted primarily of tests, including pulmonary function studies, administered by Dr. Thurman's assistants. I actually saw Dr. Thurman for about 5 minutes at each examination.
3. The assistant who took a blood sample had difficulty in getting the needle into a vein. She stuck the needle into my arm several times without success. Finally another assistant was able to obtain a blood sample.
4. The first time I saw Dr. Thurman in October, his report listed my height as 64-1/2 inches and my weight as 103 pounds. The report of the April examination listed my height as 62-3/4 inches and my weight as 110 pounds. The October report described me as a "small well-developed gentleman" and the April report described me as a "well-developed, well-nourished gentleman." Both reports concluded that I was able to perform light work activities. True and correct copies of these reports are attached hereto.
5. In fact, I am 66 inches tall and unable to work as a result of severe nutritional problems, and severe obstructive pulmonary disease.
6. In the October report, Dr. Thurman stated that I had not worked since July of 1979. In fact, I had not worked since July of 1978, after being run over by a tractor.
7. Based primarily on the reports of Dr. Thurman, my application for disability benefits was denied initially and upon reconsideration by the State Agency.
8. On July 25, 1980, and August 8, 1980, just 3-1/2 months

after seeing Dr. Thurman, I was examined by Dr. James P. Wilson for the purpose of making a disability determination. In contrast to Dr. Thurman's examinations, Dr. Wilson's examination were very thorough and lasted approximately an hour and a half. A pulmonary function study report submitted by Dr. Wilson correctly lists my height as 66 inches and my weight as 98 pounds. Dr. Wilson described me as a "somewhat wasted white male." He concluded that I was unable to perform even sedentary work activity. A true and correct copy of Dr. Wilson's report is attached hereto.

9. Dr. Roger L. Jackman, my treating physician, submitted a report dated October 6, 1980, stating that I was disabled as a result of chronic obstructive pulmonary disease since at least January 8, 1980. A true and correct copy of this report is attached hereto.

10. On February 6, 1981, an administrative law judge found that I was disabled based on satisfying a listed impairment since August 5, 1980.

11. I believe that my benefits were delayed as a result of the inadequate examinations performed by Dr. Thurman.

James E. Carney
JAMES CARNEY

Sworn to and subscribed before me this 9th day of September, 1981.

Kathy Skaggs Gibson
NOTARY PUBLIC

My commission expires: August 31, 1985



THURMAN and THURMAN, M.D.
INTERNAL MEDICINE
DISEASES OF THE CHEST

October 16, 1979

Disability Determinations Section
1808 West End Avenue, Ninth Floor
Nashville, TN 37203

RE: Carney, James E.
415-30-7453

Dear Ms. Marshall:

This patient was seen in our office on October 15, 1979. The patient is a 53 year old gentleman with a 10th grade education who last worked delivering newspapers in July of 1979. He complains of shortness of breath. This is associated with bronchitis. I am sorry to say he still smokes half a pack a day. He is dyspneic to one block on the flat or half a flight of steps on incline. He has one pillow orthopnea. I cannot tell that he is taking any specific medication.

The patient has arthritis in his wrists, knees and elbows. This is worse with inclement weather. Tylenol has some effect but there is still tenderness and 30 to 60 minutes of morning stiffness.

Low back pain is almost continuous. The precise cause of this is uncertain. It radiates into his hips. There is no history of specific trauma or of corrective surgery.

Past Medical History:

He has had a hernia repair.

Review of systems that he has night cramps but no history of claudication.

The patient's social history reveals that he smokes about 6 packs per month but doesn't smoke more than a half a pack of cigarettes a day. His physician is Dr. Jackman.

Physical Examination:

Weight: 103 lbs.
Height: 64 1/2"

B/P in right arm: 160/100
B/P in left arm: 160/100

The patient is a small well-developed gentleman who appears slightly older than his stated age. He has bags under his eyes. His liver by the way is not enlarged but is displaced by the hyperinflated lungs.

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Carney, James E.
October 16, 1979
Page 2

Head: The head is normocephalic.

Ophthalmologic: Examination of the eyes reveal that the pupils are equal and reactive. No hemorrhages or exudates are apparent on the fundoscopic examination.

Hearing: Auditory evaluation reveals that the patient can hear the spoken word normally at six feet.

Mouth: Oral exam shows no tongue ulcerations or growth.

Neck: The neck mobility is adequate. No masses or thyromegaly are noted. Bruits are not present over the carotids.

Pulmonary Exam: Auscultation and percussion are essentially normal.

Cardiac Exam: The first and second heart sounds are of normal quality and intensity. An S-3 and S-4 were not present. Auscultation did not reveal a murmur.

Abdomen: No rebound is present. The bowel sounds are normal. No organomegaly or masses are palpable.

Back: The patient only has 55 degrees of anterior flexion of the lumbar spine preserved. There is paraspinous muscle spasm on the left.

Peripheral Joints: Examination did not reveal articular effusions, periarticular muscle wasting or instability. The joints were non-deformed and had an adequate range of motion.

Extremities: No fluid accumulation could be palpated in the lower extremities. The digits have not become clubbed. No cyanosis was detectable.

Neurological Exam: There is no evidence of stupor. The sensation is intact and the cerebellar function adequate. The deep tendon reflexes are also intact and equal. The muscle strength is good on both the right and left.

Laboratory Data:

The Chest x-ray reveals Ghon's complex in the right lower lobe with huge densely calcified lymph nodes in the right perihilum and in the mediastinal lymph nodes. Significance of this is uncertain. CT ratio is 10/26 cms. The lung markings are otherwise normal.

The creatinine is .4.

Pulmonary functions were maximally done and reveal no critical loss of pulmonary reserve. On the vertical axis one inch is equal to one liter and on the horizontal axis the paper speed is one inch or a quarter inch per second. The forced expiratory volume for one second (FEV₁) is 1.8 liters pre-Isuprel and 1.8 liters post-Isuprel inhalation. The maximum voluntary ventilation (MVV) is 69.0 liters pre- and 63.0 liters post-bronchodilator. The forced vital capacity (VC) pre-Isuprel is 2.6 liter and post-Isuprel is 2.4 liters.

Impressions:

1. Bronchitis. There is no critical loss of pulmonary reserve noted on pulmonary function studies.
2. Hypertension was coincidentally noted today. It is not markedly elevated. Certainly the creatinine does not reveal evidence of critical renal end organ damage. There is no history of angina pectoris or

Carney, James E.
October 16, 1979
Page 3

of a myocardial infarction. There is no cardiomegaly on chest x-ray. There is no evidence of congestive heart failure. There is no evidence of a stroke or subsequent neurologic deficit.

3. Peripheral arthritis. The patient still has an adequate range of motion of the major joints. There is no evidence of effusion, peri-articular muscle wasting or synovial hypertrophy.

4. Back discomfort. X-rays of the back which I forgot to mention reveal increased lumbar lordosis. The interspaces are well preserved. There is no evidence of kyphoscoliosis. There is no evidence of vertebral collapse or osteoporosis. However, there is no doubt about the paraspinal muscle spasm with decreased range of motion. I believe this will affect his physical activities.

Physical Capacity Evaluation:

Largely due to this patient's back problem, he is unable to undertake more than light physical activities on a sustained basis. There is no direct evidence of true problems with his legs. There is no evidence of loss of arterial pulsations or neurological deficiencies.

Very truly yours,



Stephen Thurman, M. D.

ST:kmg

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DISABILITY DETERMINATION SECTION

PHYSICAL CAPACITY EVALUATION

Name of Claimant: James E. Carney S/A No. 415-30-7453To: Dr. Thurman

BASED ON THE FINDINGS FROM YOUR EXAMINATION, CHECK ONLY ONE (1) BLOCK BELOW TO INDICATE THE DEGREE OF IMPAIRMENT AND/OR EXERTIONAL CAPACITY:

- ☐ (1) Slight or minimal impairment -- Impairment is non-existent or so slight that it doesn't interfere with normal activities.
- NOTE: If block one (1) above is checked, do not check any other blocks.
- ☐ (2) Heavy work -- Lifting 180 pounds maximum with frequent lifting and carrying of objects weighing up to 50 pounds.
- ☐ (3) Medium work -- Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds, or requires walking or standing, or entails pushing and pulling as described below in light work.
- ☒ (4) Light work -- Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds, or requires walking or standing to a significant degree, or requires sitting most of the time, but entails pushing and pulling of arm and/or leg controls.
- ☐ (5) Sedentary work -- Lifting 10 pounds maximum. Includes occasionally lifting and/or carrying small objects. Involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.
- ☐ (6) Less than a full range of sedentary work -- Claimant cannot perform all the functions of block (5) above.

The U.S. Department of Labor's worker trait requirements manual delineates the physical demands ascribed to various work classifications. By matching the determined physical limitations to the physical demands of the jobs, the kinds of work the claimant is physically capable of performing can be determined.

10-15-79

Date

SJR

Signature of Physician

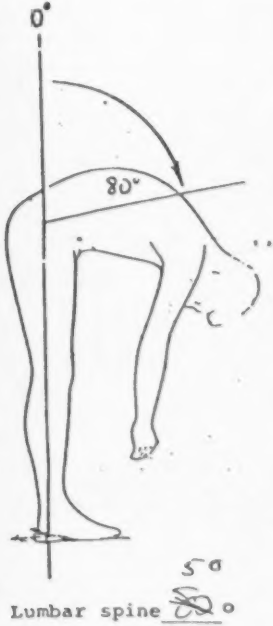
17 1979

10-15-11

JOINT RANGES OF MOTION

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Orthopedic Surgeons

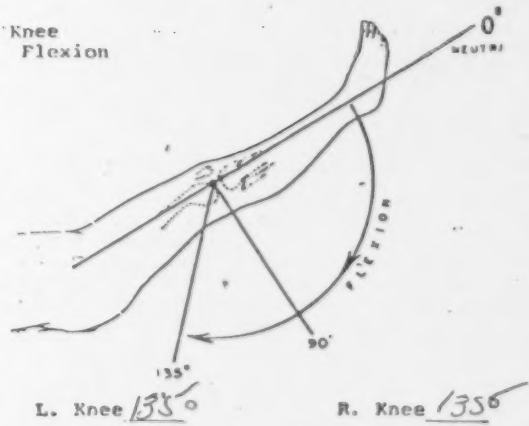
Thoracolumbar Flexion



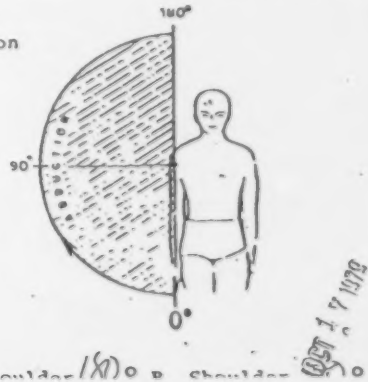
Hip Flexion



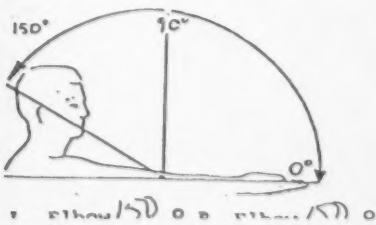
Knee Flexion



Shoulder Abduction



Elbow Flexion



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DR. THURMAN
INTERNAL MEDICINE
DISEASES OF THE CHEST

April 16, 1980

Ms. Susan Schelton
Disability Determinations Section
1808 West End Avenue, Ninth Floor
Nashville, Tennessee 37203

Re: James E. Carney
415-30-7453

Dear Ms. Schelton:

James E. Carney was examined on the 14th of April, 1980.

He is a 54 year old male with a tenth grade education who last worked delivering papers in July of 1978.

His main medical problem that he thinks keeps him from working is shortness of breath.

He returns with a large degree of the same problems that he did on our October 16, 1979 evaluation. He is still having shortness of breath and bronchitis. He is still smoking, of course. He is dyspneic to half a block on the flat or on going up a half a flight of steps on an incline. He is not taking any medications now and he is actually bringing up some more sputum. He had chest discomfort today that kept him from doing the maximal job that is necessary for objective evaluation of pulmonary functions. His sputum now is in the amount of a tablespoonful of yellow sputum a day. He has no wheezing now.

The patient's arthralgias in his low back continue. The cause is uncertain. There is no history of fracture or surgery or specific accident that brought this on. The pain is described as mild to severe on occasion. It is worsened by lifting and bending. It radiates into the left leg.

The patient has arthritis in the shoulders, elbows, ankles and knees. This is worse with inclement weather and he takes extra strength Tylenol for the pain. There is some swelling and about two hours of morning stiffness.

Review of systems reveals that the patient was noted to have some mild hypertension today. There is no history of a stroke or a myocardial infarction although the patient does have some chest pain

-2-

James E. Carney
April 16, 1980

on occasion. This occurs maybe 4 times a week. It is dull in nature. It is not related to work and responds rather nicely to extra strength Tylenol.

Past medical history reveals that he had a hernia repair in 1944.

Social history reveals that he smokes about a pack of cigarettes per day and occasionally drinks beer. His regular physician is Dr. Tackman.

Review of systems reveal that he has not had a heart attack, stroke, diabetes, cancer, liver problems, or ulcers. His nerves do sometimes bother him but he has not had to see a psychiatrist or been hospitalized and doesn't take tranquilizers.

His medications include Tylenol and Vitamins.

PHYSICAL EXAMINATION

Wt. 110 pounds.	Blood pressure (left arm) 174/102.
Ht. 62 3/4 inches.	Blood pressure (right arm) 170/106.

This is a well-developed, well-nourished gentleman who is in no acute distress. He is alert and oriented.

Head: There is no evidence of either significant mastoid or sinus tenderness. No deformity is noted in the features.

Eyes: Proptosis does not affect the position of the globes. The fundal structures are not grossly abnormal. The whiteness of the sclerae is not disturbed by icterus.

Ears: The examiner's conversation was satisfactorily understood at half-a-dozen feet. No deformation is noted of the ears. The external canals are not involved by any serious inflammatory process.

Nose: Nasal examination did not show a perforation. Air flow was not occluded by the external nares.

Throat: The tongue is nonatrophied and displays no gross tremors.

Neck: No engorgement of the jugular veins is noted when the patient assumes a sitting position. Meningismus is not present. The cervical lymph nodes are not pathologically enlarged.

Lungs: The lung fields are free of rales and wheezes. No retraction of the intercostal spaces was seen. During routine activities, the patient did not use the accessory muscles of respiration.

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-3-

James E. Carney
April 16, 1980

Heart: Palpation of the chest revealed no abnormality in the PMI. No clicks, murmurs or extra heart sounds were audible. The S-1 and S-2 were not abnormal and no ventricular lift was noted.

Abdomen: No ascites is demonstrable. The abdominal contents are not abnormal in the sense that no organomegaly is palpable.

Peripheral joints: A full range-of-motion is present in the peripheral joints. There are no severe deformities. The joints appear to be stable.

Back: The back has 60 degrees of anterior flexion of the lumbar spine preserved. There is no paraspinous muscle spasm or deformity, however. I forgot to mention, by the way, that there is a small amount of fatty tissue on the anterior aspect of the left shoulder.

Neurological exam: There is a satisfactory coordination and muscular strength in the extremities. The cranial nerves are intact and the deep tendon reflexes are active. No sensory deficits are present.

Extremities: No digital cyanosis, clubbing, or pitting ankle edema are present peripherally.

LABORATORY DATA

The patient's pulmonary functions are not maximally performed. They cannot be used as objective criteria. I believe that as long as the patient has his bronchitis and it is not too well treated that he will have some trouble doing this test. I believe that repeat pulmonary functions in the future may not give that much more objective data. On the vertical axis one inch is equal to one liter. On the horizontal axis the paperspeed is one second or four seconds. The forced expiratory volume in one second is .7 pre and .9 post-Isuprel inhalation. The maximum voluntary ventilation is 21.0 pre and 34.5 post-Isuprel inhalation. The vital capacity is 1.3 pre and 1.8 post-Isuprel inhalation.

The chest X-ray shows little change from the past studies. The CT ratio is 11/26 centimeters. The lung markings reveal some scattered calcified granulomata and a large densely calcified lymph node in the right perihilar region. This looks like an old stable process. Rib fractures at the 5th and 6th right rib laterally are noted. The diaphragms are somewhat flattened.

The electrocardiogram done in view of the history of chest discomfort

-4-

James E. Carney
April 16, 1980

is enclosed and reveals a vertical axis. There is a sinus rhythm with a rate of 63. The PR interval is .21, QRS interval is .07, and QT interval is .39. The electrical axis is +90 degrees.

The creatinine done in view of the hypertension is .4.

IMPRESSIONS

- (1) Chronic bronchitis. The patient still has a productive cough but he has good breath sounds and there is no cyanosis, wheezing, or clubbing. The X-ray does not really reveal advanced lung disease. Unfortunately, the pulmonary functions are not objectively done. In the past, the patient had quite adequate pulmonary reserve. I do not believe that it is likely in view of all of the other factors remaining stable that there has been such a marked deterioration in his pulmonary functions as the present values would suggest.
- (2) Chest pain. The nature of the chest discomfort is not similar to typical angina. There is no confirmation of an acute MI. This EKG does not have the diagnostic changes of ischemia.
- (3) Peripheral arthritis. There was no significant joint instability or effusions present. The range-of-motion of the peripheral joints was well-preserved. The peripheral joints did not have any severe deformities.
- (4) Back pain. The patient does have a diminution in the range-of-motion of his spine. There is no paraspinal muscle spasm, however, and there is no evidence of deformity such as kyphoscoliosis or instability.
- (5) Hypertension. Critically limiting end-organ damage has not occurred yet. The serum creatinine falls into a satisfactory range. The patient is functional as far as the neurological examination is concerned.
- (6) Nerves. This process has not severely restricted daily activities. Everyday financial matters can be carried out by this gentleman. The neurological examination did not reveal obtundation.

PHYSICAL CAPACITY EVALUATION

This gentleman is still capable of undertaking light physical activities on a sustained basis. I believe that his back would not allow him to do moderate physical activities.

Very truly yours, *SA Stephen Thorne*

138

RANGE-OF-MOTION STUDIES



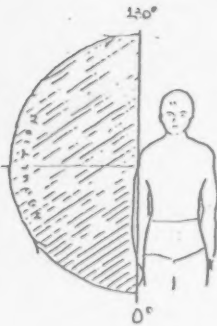
DR. THURMAN

Carroll James
4/14/80

PERIPHERAL JOINT RANGES OF MOTION

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Orthopedic Surgeons

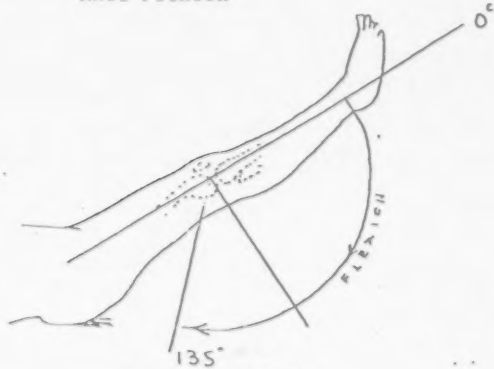
Shoulder Abduction



Left Shoulder 180 °

Right Shoulder 180 °

Knee Flexion



Left Knee 135 °

Right Knee 135 °

Elbow Flexion

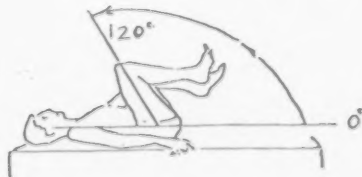
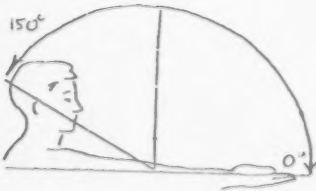
Left Elbow 150 °

Right Elbow 150 °

Hip Flexion

Left Hip 120 °

Right Hip 120 °

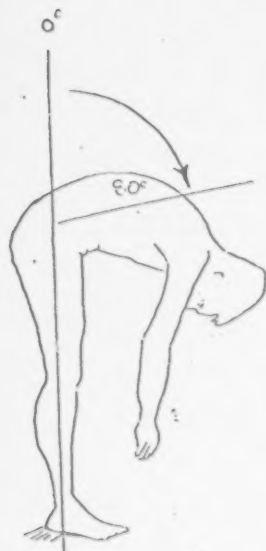


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LUMBOSACRAL RANGES OF MOTION

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Thoracolumbar Anterior Flexion



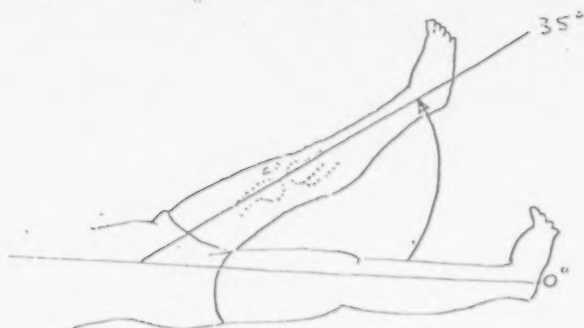
Anterior 60°

Lumbosacral Extension



Extension 30°

Straight Leg Raising



Left Hip 35° Right Hip 35°



Lumbosacral Lateral Flexion

Left Side 20° Right Side 20°

FINGER FLEXION

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LEFT HAND

FILLED IN ONLY IF ABNORMAL

RIGHT HAND

2 3 4 5

2 3 4 5

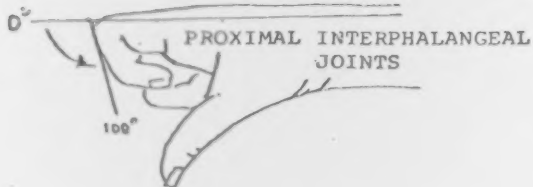


LEFT HAND

RIGHT HAND

2 3 4 5

2 3 4 5



LEFT HAND

RIGHT HAND

2 3 4 5

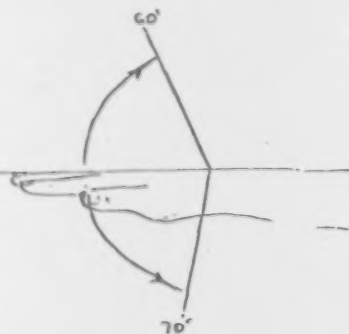
2 3 4 5



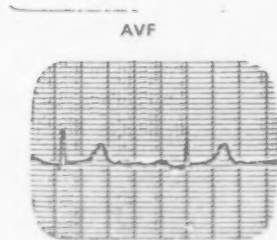
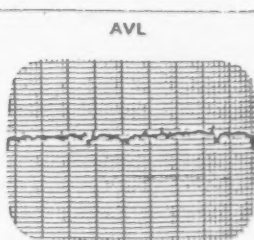
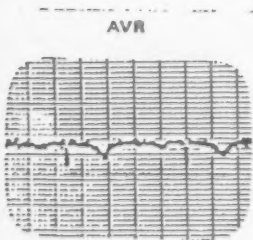
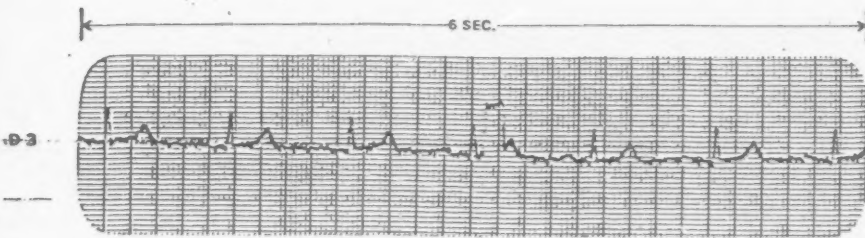
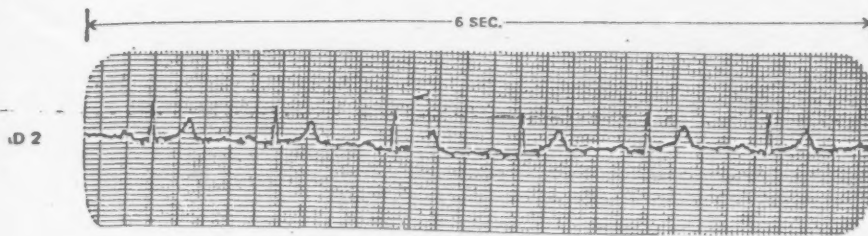
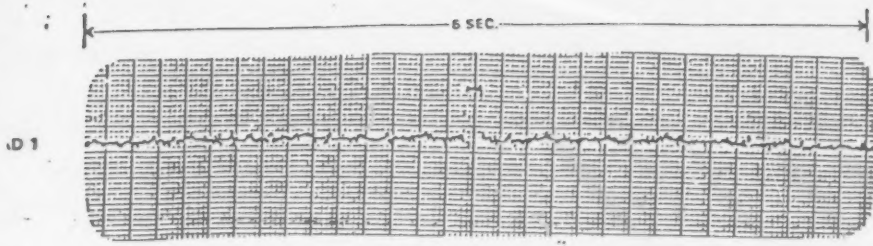
EXTENSION AND FLEXION OF THE WRIST

LEFT WRIST

RIGHT WRIST

EXTENSION 60°EXTENSION 60°FLEXION 70°FLEXION 70°

- 21 1980



PHYSICAL CAPACITIES EVALUATION

Claimant James Carney SSN 415-30-7453

Please complete the appropriate items on this form based on the medical findings only, and not on the claimant's subjective complaints, age, sex, etc.

1. ☐ Check this block if the medical findings show no significant reduction in physical capacities, i.e., no significant physical impairment. If this block is checked, skip to item 6.

2. Based on the medical findings, check one of the following blocks to indicate the claimant's capacity for lifting and carrying.

- ☐ 100 pounds occasionally to 50 pounds frequently
☐ 50 pounds occasionally to 25 pounds frequently
☒ 20 pounds occasionally to 10 pounds frequently
☐ 10 pounds or less frequently

3. Based on the medical findings, please indicate the claimant's capacity for WALKING, STANDING, and SITTING by circling the appropriate number of hours per day that the claimant can perform that function. If unimpaired, circle that word. Please explain any restriction in your narrative report.

WALKING (circle number of hours) 0 1 2 3 4 5 6 7 8 Unimpaired

STANDING (circle number of hours) 0 1 2 3 4 5 6 7 8 Unimpaired

SITTING (circle number of hours) 0 1 2 3 4 5 6 7 8 Unimpaired

4. Based on the medical findings, please indicate the claimant's capacity for BENDING and REACHING by circling the appropriate word to indicate how frequently the claimant can perform that function. If unimpaired, circle that word. Please explain any restriction in your narrative report.

BENDING (circle word) Never Occasionally Frequently Unimpaired

REACHING (circle word) Never Occasionally Frequently Unimpaired

- Based on the medical findings; please indicate the claimant's capacity to use the extremities in work activity. Please explain any restriction in your narrative report.

RIGHT UPPER EXTREMITY Restricted ☐ Not Restricted ☒

LEFT UPPER EXTREMITY Restricted ☐ Not Restricted ☒

RIGHT LOWER EXTREMITY Restricted ☐ Not Restricted ☒

LEFT LOWER EXTREMITY Restricted ☐ Not Restricted ☒

S.R.
 Signature of Physician

4-14-50
 Date

AFFIDAVIT

STATE OF TENNESSEE)
COUNTY OF SUMNER)

WILLIAM L. NEWLAND, being duly sworn, deposes and
says:

1. I am 57 years old and reside at Route 3, Portland, Tennessee 37148.

2. In July, 1972, I was examined by Dr. Howard R. Foreman at the request of the Disability Determinations Section of the Social Security Administration. He concluded that because of my emphysema I could only do sedentary work. Based on his examination, a determination of disability was made and I began to receive disability payments in 1972. A copy of Dr. Foreman's report is attached as Exhibit "1".

3. In April, 1979, I was examined by Thurman & Thurman for a periodic review of my disability. Dr. Peter Thurman concluded that I was capable of doing medium work. A copy of Dr. Thurman's report is attached as Exhibit "2".

4. In June, 1979, I was examined by Thurman & Thurman and Dr. Stephen Thurman concluded that I was capable of doing medium work. A copy of Dr. Thurman's report is attached as "Exhibit "3".

5. Both the April and June examinations consisted mainly of tests taken by one of Dr. Thurman's assistants. This assistant took my weight and blood pressure. She made a chest X-ray, administered the pulmonary function study, and took a blood sample.

6. The assistant making the chest X-ray during the April examination had difficulty getting a good X-ray. She had to take two or three X-rays before she got one that was acceptable. The X-ray machine appeared to be very old.

7. The pulmonary function study made during the April examination was very unsanitary.

Exhibit 4

8. Dr. Thurman's examination of me in April took only about two or three minutes. He looked at my X-rays and listened to my back with his stethoscope. That was the entire examination.

9. During the June examination, the assistant who was taking my blood sample had difficulty getting the needle into my vein. She put the needle in my arm several times. Finally, another assistant came and put the needle in my other arm.

10. The examination of me in June consisted only of Dr. Thurman hitting my leg with a hammer and telling me to lift my arms above my head. He did not look at my eyes, ears, nose, or anything else.

11. Because of the reports submitted by Dr. Thurman, my disability payments were cut off and I did not receive any disability payments for approximately 18 months.

12. In February, 1980, at the request of my attorneys, Legal Services of Middle Tennessee, I was again examined by Dr. Foreman. He reaffirmed his findings of 1972, and concluded that I was still suffering from emphysema and could only do sedentary work. Both of Dr. Foreman's examinations were very complete, in contrast with those of Dr. Thurman. A copy of Dr. Foreman's report is attached as Exhibit "4".

13. In October, 1980, the Administrative Law Judge ruled that my disability had not ceased and ordered my benefits reinstated. A copy of the Administrative Law Judge's decision is attached as Exhibit "5".

William L. Newland
WILLIAM L. NEWLAND

Sworn to and subscribed before me this 17th day of August, 1981.

Judith Ann Headon
NOTARY PUBLIC

My commission expires: June 14, 1983



THURMAN and THURMAN, M.D.
INTERNAL MEDICINE
DISEASES OF THE CHEST

April 7, 1979

Disability Determination Section
1808 West End Avenue - Ninth Floor
Nashville, Tennessee 37203

RE: WILLIAM NEWLAND
154-22-2919

Dear Ms. Conley:

I first saw this patient in my office on April 6, 1979. The patient is a 56-year old white male who stands 70 inches and weighs 162½ pounds and is referred in for pulmonary function testing and chest x-ray.

The patient has a long-term history of emphysema and the positive findings have been found on physical exam as well as chest x-ray and the pulmonary function testing done in July of 1972. He has no history of lung surgery.

I examined the patient and found him to have some mild decreases in breath sounds in the lung bases with scattered expiratory wheezes. I heard no rales or rubs in the lung fields and the breath sounds were of good quality in the upper lung fields.

Pulmonary functions were done and are enclosed. The pulmonary functions were done with vigor and showed good patient cooperation. The scale for the pulmonary functions were one liter per inch on the vertical axis and one second or four seconds per inch on the horizontal axis. The actual values are with the tracings. They indicate good pulmonary reserve so that there should be no decrease in physical capacity. The forced expiratory volume for one second (FEV-1) is 1.6 liters pre-Isuprel and 1.9 liters post-Isuprel inhalation. The maximum voluntary ventilation (MVV) is 76.5 liters pre- and 72.0 liters post-bronchodilator. The forced vital capacity (VC) is 2.8 liters pre-Isuprel and 3.0 liters post-Isuprel inhalation.

The chest x-ray PA projection was done as requested. The chest x-ray showed a CT ratio of 13/32 cm. The heart was of normal size and configuration. The lung fields revealed a few scattered granulomata as well as some mild increase in markings in the lower lobes compatible with some early fibrotic changes. The diaphragms were mildly flattened bilaterally. This was consistent with moderate obstructive pulmonary disease, but there was no evidence of congestive heart failure.

ANN
EXHIBIT 18 (4 Pgs) APR 10 1979

OVERALL IMPRESSIONS AND PHYSICAL CAPABILITY STATEMENT:

We do indeed feel that Mr. Newland has obstructive pulmonary disease as evidenced by chest x-ray. We still feel, however, that he is capable of moderate physical activities in regard to this as evidenced by the results of his pulmonary function testing still showing adequate pulmonary reserve.

Very truly yours,

P. L. Thurman

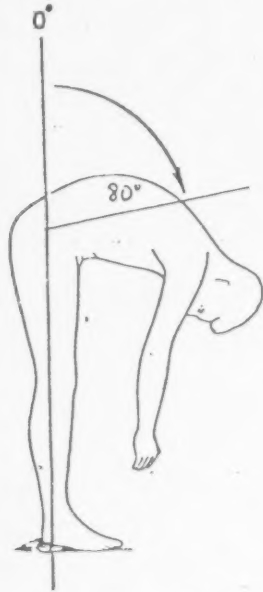
Peter L. Thurman, M.D.

BEST AVAILABLE COPY

JOINT RANGES OF MOTION

Used by Dr. Thurman with permission of the American College of Orthopedic Surgeons

Thoracolumbar Flexion



Lumbar spine 80°

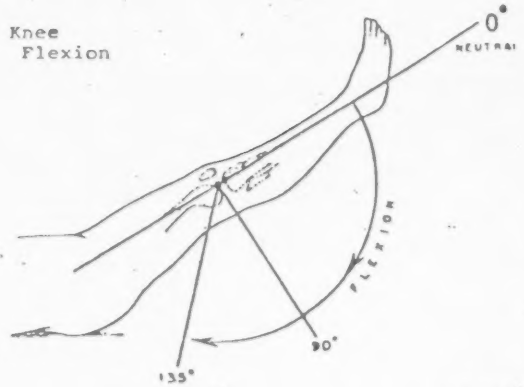
Hip Flexion



L. Hip 120°

R. Hip 120°

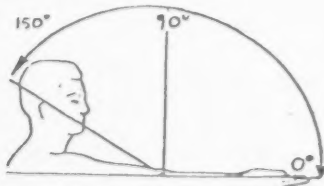
Knee Flexion



L. Knee 135°

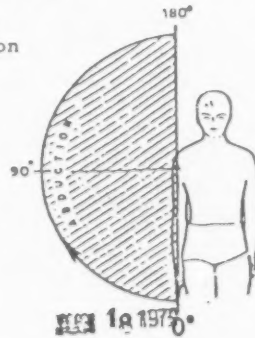
R. Knee 135°

Elbow Flexion



L. Elbow 150° R. Elbow 150°

Shoulder Abduction



L. Shoulder 180° R. Shoulder 180°



THURMAN and THURMAN, M.D.
INTERNAL MEDICINE
DISEASES OF THE CHEST

June 13, 1979

Disability Determination Section
1808 West End Avenue - Ninth Floor
Nashville, Tennessee 37203

RE: NEWLAND, WILLIAM
SS: 154-22-2919

Dear Ms. Conley:

I first saw this patient in my office on June 9, 1979. Mr. Newland is a 56-year old gentleman with a first grade education ^{4th} who last worked as a garbage man seven years ago. He has previously been evaluated here with a chest x-ray and pulmonary functions which showed still moderate reserve on his physical capacity evaluation. He also has chest pains. These occur three to four times per week. They are in the left side of the chest and also in the sternal region. There are sharp in nature and last two to three minutes. They are not emphatically related to work.

The patient has arthralgias in his knees and shoulders. This is worse in inclement weather. There is some tenderness and swelling with about two hours of morning stiffness.

The patient has emphysema with dyspnea, but still has adequate reserve for moderate physical activities on recent pulmonary function studies.

The patient has been under treatment with appropriate medications for his hypertension for the last seven years. There is no history of a stroke or of a myocardial infarction.

SOCIAL HISTORY:

The patient smokes three to four cigarettes a day, but doesn't drink alcoholic beverages. His physician is Dr. Waco.

PHYSICAL EXAMINATION:

HEIGHT: 70 inches.
WEIGHT: 163 pounds.

LEFT ARM B/P: 190/100.
RIGHT ARM B/P: 184/98.

The patient is a well-developed, well-nourished gentleman with very slight kyphosis. He is alert, oriented, and cooperative.

HEAD: The head appears normal and the face is not disfigured.

JUN 18 1979

217-20(4 ppp)

-2-
NEWLAND, WILLIAM
June 13, 1979

AUDITORY: The auditory acuity is preserved such that the patient can hear a normal conversation at six feet.

OPHTHALMOLOGIC: The conjunctivae are not inflamed and the sclerae are clear. The retinae are free of hemorrhages and exudates.

NASAL: The nose is not distorted. The external nares are open.

MOUTH: No glossal ulcers are noted. The swallowing mechanism is unimpeded.

NECK: Palpation does not reveal an enlarged thyroid or lymphadenopathy. Auscultation does not reveal bruits.

CHEST: There is mild decrease in the breath sounds. No rales were heard today or wheezes described.

HEART: Cardiomegaly is not clinically detectable. No pre-systolic or protodiastolic sounds are present. No murmurs were found. The first and second heart sounds are physiological.

ABDOMINAL: The liver and spleen are not enlarged. No kidney or mass is palpable. There is no ascitic fluid or fistulous tract. The bowel sounds are of a normal intensity and quality.

MUSCULOSKELETAL: The physical shows no evidence of effusion, peritricular muscle wasting, or joint instability. The range of motion is adequate. The major joints are not deformed.

NEUROLOGICAL: Performance of the deep tendon reflexes revealed no asymmetry or abnormal intensity. The pathological reflexes are negative. CN function is not impaired. The sensation and strength are preserved both on the right and left.

EXTREMITIES: No clubbing, cyanosis, or edema is detectable.

BACK: Range of motion testing was satisfactorily performed. No paraspinous muscle spasm was clinically present. The spinal curvature did not display any deformity. This includes not only the lumbosacral, but also the cervical and thoracic spine.

LABORATORY DATA:

The patient's electrocardiogram reveals an essentially normal tracing. There is some low voltage in the frontal leads.

The creatinine, done in view of the finding of hypertension, is 1.0 mg. percent.

JUN 18 1979

-3-

NEWLAND, WILLIAM
June 13, 1979

Urinalysis was done and was clear with a pH of 8. It was negative for protein and glucose.

IMPRESSIONS:

(1) CHEST PAIN: There is no evidence of congestive heart failure. The recent chest x-ray revealed no cardiomegaly. There is no pedal edema, jugular venous distention, or hepatic engorgement. Also, there is no history of exertional chest pain. The angina is, therefore, atypical. Furthermore, the electrocardiogram did not reveal changes diagnostic of ischemia or of an old myocardial infarction.

(2) ARTHALGIAS, PERIPHERALLY: The patient still has a good range of motion of the major joints. There is no evidence of effusion, periarticular muscular wasting, or synovial hypertrophy.

(3) HYPERTENSION: There is no evidence of critical end organ damage. The creatinine is less than 3.0 mg. percent. There is no evidence of a stroke or subsequent neurological deficits. There is no evidence of an old myocardial infarction. There are no hemorrhages or exudates on the eye ground examination.

PHYSICAL CAPACITY EVALUATION:

This patient still has adequate pulmonary reserve for moderate physical activities--has no further loss of physical capacity on the basis of the above outlined problems. His physical capacity, therefore, is still at the moderate level.

Very truly yours,

S-T

Stephen S. Thurman, M.D.

SST:ap

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF WARREN

Comes James E. Redmon, after being duly sworn, and states as follows:

I applied for Social Security disability in January 1981. In February 1981, I was given an appointment with Dr. Thurman for an examination. My attorney, Kathleen A. Maloy with Legal Services of South Central Tennessee, asked me to make a statement about what happened during that examination. I have seen a copy of Dr. Thurman's report. However, I do not read very well. Because of this, my attorney has read the report to me and explained parts that I did not understand.

On February 26, 1981, I went to the office of Dr. Thurman. I was seen first by a nurse. She asked me some questions about my medical history, weighed me, and had me do some breathing tests. I was with her for about thirty minutes.

After that Dr. Thurman came into the room to see me. He asked me about how the accident happened which hurt my left foot and leg. He looked at my left knee but he did not take the sock off my foot. He never saw my left foot bare. He asked me to take four or five steps and then asked me to bend over and try to touch the floor, which I couldn't do. While I was lying on the table, he bent my left leg back underneath my knee. It really hurt me and I told him so. He also bent my right leg back underneath the knee. He looked in my mouth and in my ears.

Exhibit 5

He listened to my heart and back with his stethoscope. He did not look at any other parts of me. While I was lying on the table, he did not use his hands to examine any part of my stomach or chest. He did not ask me any other questions. I was with Dr. Thurman for about ten minutes.

I understand that Dr. Thurman's report says that I have only some pain in my back and that I was not taking any medication. At that time, I was taking medicine for the arthritis pain in my back and for my breathing problems. However, I was not asked any questions about my back pains and breathing problems. I also was not asked if I was taking any medicine. I also told Dr. Thurman about the bad pain in my left leg and foot, especially when he bent my leg back. I also understand that Dr. Thurman's report shows that he had me ^dto some range of motion tests. My attorney has explained to me what these tests are about. The only things Dr. Thurman had me do were bend over forward and while I was on the table he bent both my legs back. He also asked to lift up both legs while I was lying down. He did not ask me to bend backwards or sideways, he did not ask me to move or flex my hands, he did not ask me to do any other bending, lifting or moving with either my arms or legs. I also have problems hearing because I am almost deaf in one ear. Dr. Thurman's report says that I can hear without any problems up to six feet. However, he only spoke to me one time and then he was standing right beside me. I understand that Dr. Thurman talked about how my foot looked in his report. Dr. Thurman never saw my left foot without a sock on.

I feel like Dr. Thurman hardly examined me at all and I don't understand how he could have written so much in his report, especially saying that my problems with my left leg and foot and breathing aren't very serious. In December 1981, I had another examination by a Social Security doctor. He spent over three and a half hours with me and asked some other doctors to come in to look at my foot. I feel like I know when a doctor really examines me.

Further, Affiant Sayeth Not.

James E. Redmon
JAMES E. REDMON

Sworn to and subscribed before me this the 4
day of FEBRUARY, 19 82.

David H. Kalcuska
NOTARY PUBLIC

My Commission Expires:

15 JUL 82

STATE OF TENNESSEE)
COUNTY OF SMITH)

DECLARATION OF INA L. BURTON

Ina L. Burton declares under penalty of perjury:

1. I am a citizen of the United States and a resident of Buffalo Valley, Smith County, in the State of Tennessee. I currently live with my daughter Linda Harris, since I have no income and I am unable to maintain my own household.

2. I am 52 years old. In 1969, I passed the exam which qualified me as a licensed practical nurse. As a licensed practical nurse, I assisted doctors in doing examinations on patients. In addition, I have worked in a hospital nursery, in the x-ray room, on the wards administering to patients, as well as the nurse solely responsible for the emergency room at Smith County Memorial Hospital. In my 26 years of work, I have had a lot of experience working with patients, working with doctors, and assisting with patient's examinations. Before being licensed, I worked as an aide both in a nursing home and a hospital.

3. I applied for Social Security and Supplemental Security Income Disability Benefits on December 18, 1980. I left my job on December 5, 1980, when I realized I could no longer continue my work. I was denied when I first applied and requested reconsideration on February 19, 1981. My claim was again denied, and I requested a hearing before an administrative law judge. I had a hearing on October 24, 1981, ten months after I had applied. I still have not received a decision in my claim.

4. On January 15, 1981, I was sent to a consultative medical examination by the Disability Determination Section in

Tennessee. My examination was with Suburban Internal Medicine Group in Nashville, Tennessee. My daughter accompanied me to this exam.

5. When I went to the exam, I did not wait long to be examined. I was brought into the doctor's inner office by a young woman. I am not sure if she was a nurse or an aide. She checked my height and weight and obtained a brief history. After she had done this preliminary work, I was brought into an examining room and I was instructed to remove my clothes from my waist up and get on the examining table. I did these things and then waited for the doctor to come in.

6. The doctor came in and immediately came over to me and introduced himself as Dr. Thurman. He did not say anything to me until he was standing over me. He did a brief examination. He used a stethoscope to listen to my heart and breathing. He barely touched my body with his stethoscope and left it on me so briefly that he could not have been able to assess my problems with my breathing. He barely looked at my ear and didn't say anything about any redness, infection, or disfigurement. He did not test my hearing. Dr. Thurman discovered the pain in my right shoulder, only when I told him about it. My shoulder is very painful and when he then touched me I reacted. He ordered his assistant to take an x-ray of my shoulder. That was all Dr. Thurman did in his examination of me. He examined me for about 3 or 4 minutes, all together.

7. The Doctor's assistant did the rest of my examination. I had an x-ray done on my chest and shoulder and I had a breathing test performed. I was very surprised at the manner of the person who did my breathing test. I don't know if she was a nurse or not, but she really tried to push me very hard.

She kept hollering at me "come on, come on, breathe harder, breathe harder," and I did the best I could. I felt like I was put under some unnecessary pressure by her hollering at me and snapping her fingers and wanting me to breathe to the rhythm of her fingers. She put the clamp on my nose for the breathing test and I had to keep taking it off because I couldn't get any air and couldn't breathe. I have taken other breathing tests and had never been treated that way before.

8. I was very surprised when I looked over the report that was done by Dr. Thurman. The report looked like he had done much more than he had and there was much information that was incorrect. I was surprised to find that I was 61 inches tall rather than 62 inches tall. I was very much surprised to find that I had no trouble hearing spoken conversation. I have a great deal of trouble hearing. I have a 70 decibal hearing loss in my right ear and I have a great deal of pain in my face as a result of a disorder of the meniscus. I could not believe that there wasn't an obvious deformity in and around my right ear. I was to be operated on later in 1981 for that exact deformity.

In addition, it was very surprising to me to find that I had no clubbing in my extremities. I have a very distinct deformity in my feet, that would be obvious even to a lay person. I was very surprised to find that I had no particular problem with my ulcers. I have three separate kinds of ulcers. I have a peptic ulcer, a duodenal ulcer, as well as a chronic crater in my stomach. It gives me a great deal of trouble, and if anyone would have asked about them or examined me completely, they would have known that.

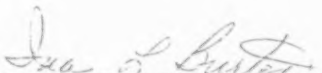
9. I was very surprised to find that there were reports of ranges of motion studies attached to the report that the doctor or the nurse supposedly had done. They didn't do them while I was at the office that day. The only thing the doctor knew was that I had trouble with my right shoulder. There were many of those range of motion tests that I could not do because of pain that I experience.

10. I cannot believe that this examination is being used to deny me my disability benefits. I have worked for many years and I have raised my children on my own, and it has upset me a great deal to find that I now have to live with my child because I have no money to support myself. I have paid in my earnings, and now I have nothing. I could not believe that Dr. Thurman put things in a report that he had not done and included information that was not correct. My own doctors have sent in letters as well as reports of my hospitalizations and tests and those will show all of the things that are wrong with me.

11. I have no reason to lie, I have been a licensed practical nurse for many years, and Dr. Thurman's exam was far from complete. I hope that other people will not have to suffer as I have because of Dr. Thurman's incomplete and incorrect medical reporting.

I verify under penalty of perjury that the foregoing is true and correct.

Executed on Jan. 30th, 1982


Ina L. Burton

SUBURBAN INTERNAL MEDICINE GROUP

January 17, 1981 ✓

Mr. John Guffey
Disability Determinations Section
1808 West End Building - Ninth Floor
Nashville, Tennessee 37203

Re: Ina L. Burton
414-50-9112

Dear Mr. Guffey:

We appreciate the opportunity to examine Ms. Ina Burton on January 15th, 1981. Ms. Burton is a 51 year old female with a G.E.D. and LPN training who last worked as an LPN in 1980. [Ms. Burton comes in mostly because of ear problems.]

Ms. Burton has a problem with mastoiditis twice in the past, that has required surgery. She subsequently has had a hearing loss upon her right side. There has not been any significant hearing loss on her left side. She has also had problems with otitis externa in her right ear.

Ms. Burton has a history of shortness of breath, which she has had for two years. She gets short of breath on going one-half block on the flat or up one-half flight of stairs. She sleeps on one to two pillows at night and has a history of swelling of the ankles. She supposedly has emphysema. She has a cough productive of a teaspoon of brown-yellow sputum. She also has a history of wheezing.

Ms. Burton has had high blood pressure diagnosed for four or five years. She takes no medication for this and has never had a stroke as a result of the hypertension.

Ms. Burton has had diabetes diagnosed for one month. She is on a diabetic diet, but takes no medication for this. She has never had a stroke as a result of the diabetes.

EXHIBIT

20

(17 pgs)

1981

Ina L. Burton
January 17, 1981

Past medical history - Ms. Burton has been hospitalized within the last year for her ear, heart and back. She has had right ear surgery twice in the past. She has also had a cholecystectomy and hysterectomy.

SOCIAL HISTORY

Ms. Burton smokes a pack and a half of cigarettes per day, but does not drink alcoholic beverages. She is followed by Dr. Green.

Review of systems:

Ms. Burton has arthritis of the right shoulder (this joint is the worst), right knee, both wrists, and the neck. This arthritic pain is worse with inclement weather. She takes no medication for this. She has never received any gold injections, but was on Cortisone four months ago. There is tenderness and swelling of the joints, but no redness has been noted.

Ms. Burton has a hiatal hernia for which she has never had surgery for. She has no problems from the hernia presently.

→ There is no particular problem with chest pain, heart attack, stroke, cancer, [ulcer disease], hepatitis or epilepsy.

Medications - She is upon Lasix, Valium, Theolair.

PHYSICAL EXAMINATION

196 lbs. 12-5

BP 160-100

Weight: 177 pounds B/P in right arm: 150/90
Height: 61 inches 5'2" B/P in left arm: 150/84

This is a well-developed, well-nourished lady who is somewhat obese. She appears to be about her stated age. She has greying hair. [She had no trouble hearing a normal spoken conversation around the office today.]

Head: No acute sinus or [mastoid tenderness] is present. The facial features are not deformed.

Neck: When in a vertical position, the venous pulses are not visible in the neck. Significant cervical adenopathy as well as meningismus were not found.

Eyes: The ophthalmoscopic exam did not demonstrate advanced exudates or hemorrhages. The sclerae are not yellow. Inflammation is not noted of the conjunctivae.

JAN 21 1981

How do you determine that?

-3-

Ina L. Burton
January 17, 1981

Ears: There is some tenderness of the external right ear. Otherwise, the tympanic membranes are intact. There is an old surgical scar over the right mastoid, but no significant deformity. The patient can hear a normal conversation easily at six feet.

Nose: The septum of the nose is unperforated. Air flow was not impeded at the level of the nares.

Mouth: No asymmetry is evident on palatal examination. The glossal papillae show no evidence of atrophy.

Heart: The heart sounds are not muffled. The heart examination was not positive for a murmur. Neither a right ventricular lift nor a thrill could be felt. Also, no gallops were audible. The apex beat has not shifted to the left.

Lungs: The breath sounds are bronchovesicular. Neither rales or rhonchi are heard. The excursion of the diaphragms is unimpaired.

Abdomen: The bowel sounds are normal. There is no significant palpable liver, kidney or spleen. The abdomen has no ascites or shifting dullness.

Back: The paraspinous muscles are not in spasm and there is a good back range of motion. No nerve root compression is demonstrable.

Peripheral Joints: There is a full range of motion in all of the peripheral joints, except for the right shoulder. The right shoulder is only able to abduct to approximately 160 degrees before this patient stops because of shoulder pain. This is her stiffest joint. There is no evidence of deformity, swelling, or increased heat, though, in the right shoulder. There is no evidence of other peripheral joint deformity.

Extremities: No clubbing, cyanosis or edema was apparent.

Neurological: Muscular strength and sensation are well preserved. The deep tendon reflexes and the cranial nerves are intact. The coordination is good.

LABORATORY DATA

X-ray of the right shoulder AP and Lateral - This appears to be stable. The shoulder joint is well intact. There is no evidence of cortical erosion or of narrowing of the shoulder joint itself. It appears to be quite stable.

PA chest x-ray - This shows a CT ratio of 14.5/29.0. There

-4-

Ina L. Burton
January 17, 1981

is no significant flattening of the diaphragms or hyperlucency of the bases. There are no changes here particularly suspicious of obstructive pulmonary disease. The heart is of a normal size and configuration. There is no evidence of upper lobe venous distention or interstitial edema. I would consider this a benign x-ray.

Pulmonary function studies - On the vertical axis, one inch is equal to one liter. On the horizontal axis, one inch is equal to either one second for the vital capacity or to four seconds for the maximum voluntary ventilations. These studies are done with good understanding and good cooperation. The forced expiratory volume for one second (FEV1) is 2.1 liters pre-Isuprel and 2.2 liters post-Isuprel inhalation. The maximum voluntary ventilation (MVV) is 82.5 liters pre- and 87.0 liters post-bronchodilator. The forced vital capacity (VC) pre-Isuprel is 2.3 liters and post-Isuprel is 2.4 liters. There is an adequate pulmonary reserve present here. With this pulmonary reserve, there would appear to be no significant decrease in physical capacity secondary to any sort of decrease in pulmonary reserve.

Creatinine, obtained due to history of diabetes, is .4.

IMPRESSIONS

1. POOR HEARING IN THE RIGHT EAR - Ms. Burton still has quite adequate hearing in her left ear and is easily able to hear a normal spoken conversation at six feet today.
2. SHORTNESS OF BREATH - The current x-ray does not show evidence of advanced chronic obstructive lung disease. Upon reading the pulmonary function studies, I can find no evidence of a significant loss of respiratory reserve. Auscultation of the lungs detected no wheezes or rales and the lips did not appear cyanotic.
3. HYPERTENSION - There are no critically limiting neurological deficits. The creatinine was not significantly elevated. I could find no direct evidence of major cardiovascular complications.
4. DIABETES - The creatinine was not significantly elevated. There are no critical hemorrhages or exudates. There are no critically limiting neurological deficits.
5. ARTHRITIS - The x-rays do not show critical abnormalities. There are no effusions or periarticular muscular wasting. The peripheral joints were able to go through a good range of motion.

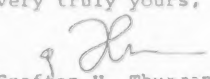
JAN 21 1981

6. HERNIA - Daily activities are not seriously hampered. No serious complications have supervened.

PHYSICAL CAPACITY EVALUATION

Ms. Burton would still appear to be capable of light physical activity.

Very truly yours,


Grafton H. Thurman, M.D.

GHT/cf

PHYSICAL CAPACITIES EVALUATION

Claimant Ina Burton SSN 414-50-9112

Please complete the appropriate items on this form based on the medical findings only, and not on the claimant's subjective complaints, age, sex, etc.

1. ☐ Check this block if the medical findings show no significant reduction in physical capacities, i.e., no significant physical impairment. If this block is checked, skip to item 6.
2. Based on the medical findings, check one of the following blocks to indicate the claimant's capacity for lifting and carrying.

- ☐ 100 pounds occasionally to 50 pounds frequently
☐ 50 pounds occasionally to 25 pounds frequently
☒ 20 pounds occasionally to 10 pounds frequently
☐ 10 pounds or less frequently

3. Based on the medical findings, please indicate the claimant's capacity for WALKING, STANDING, and SITTING by circling the appropriate number of hours per day that the claimant can perform that function. If unimpaired, circle that word. Please explain any restriction in your narrative report.

WALKING (circle number of hours) 0 1 2 3 4 5 6 7 8 Unimpaired

STANDING (circle number of hours) 0 1 2 3 4 5 6 7 8 Unimpaired

SITTING (circle number of hours) 0 1 2 3 4 5 6 7 8 Unimpaired

4. Based on the medical findings, please indicate the claimant's capacity for BENDING and REACHING by circling the appropriate word to indicate how frequently the claimant can perform that function. If unimpaired, circle that word. Please explain any restriction in your narrative report.

BENDING (circle word) Never Occasionally Frequently Unimpaired

REACHING (Circle word) Never Occasionally Frequently Unimpaired

5. Based on the medical findings, please indicate the claimant's capacity to use the extremities in work activity. Please explain any restriction in your narrative report.

RIGHT UPPER EXTREMITY Restricted ☐ Not Restricted ☒

LEFT UPPER EXTREMITY Restricted ☐ Not Restricted ☒

RIGHT LOWER EXTREMITY Restricted ☐ Not Restricted ☒

LEFT LOWER EXTREMITY Restricted ☐ Not Restricted ☒

6. [Signature]
 Signature of Physician

1-15-81
 Date

DD-24 (Rev. 12/79)

JAN 21 1981

BEST AVAILABLE COPY

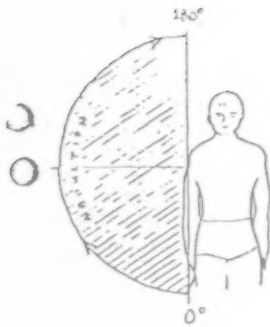
Lina Gordon

1-15-81

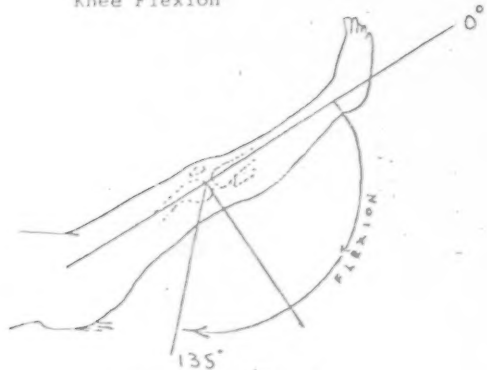
PERIPHERAL JOINT RANGES OF MOTION

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Shoulder Abduction

Left Shoulder 180°Right Shoulder 160°

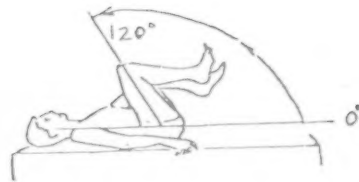
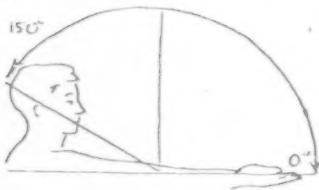
Knee Flexion

Left Knee 135°Right Knee 135°

Elbow Flexion

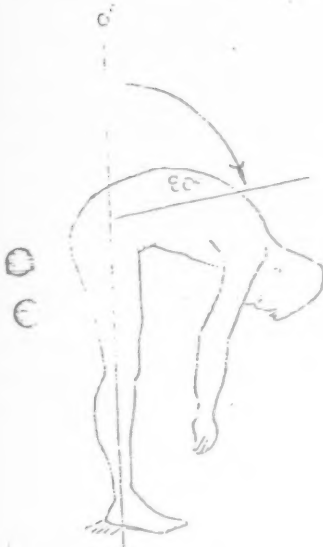
Left Elbow 150°Right Elbow 150°

Hip Flexion

Left Hip 120°Right Hip 120°

LUMBOSACRAL RANGES OF MOTION

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Orthopedic Surgeons
Thoracolumbar Anterior Flexion



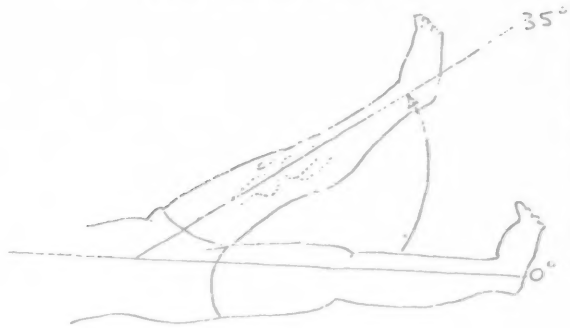
Anterior 80 °

Lumbosacral Extension

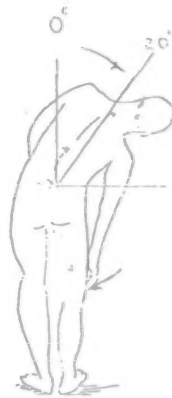


Extension 30 °

Straight Leg Raising



Left Hip 35 ° Right Hip 35 °



Lumbosacral Lateral Flexion

Left Side 20 ° Right Side 20 °

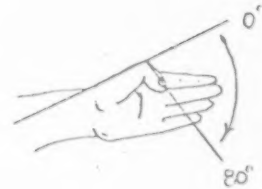
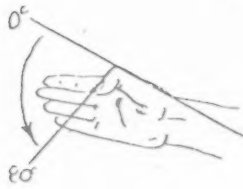
18M 6

Flexion of the Thumb

Fill in only if abnormal



Zero starting position



Interphalangeal joint



Metacarpophalangeal joint



Carpometacarpal joint

Right

Left

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FINGER FLEXION

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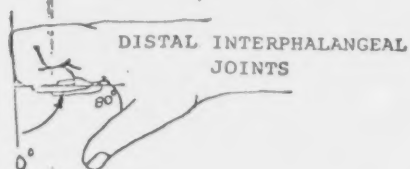
LEFT HAND

2 3 4 5

FILLED IN ONLY IF ABNORMAL

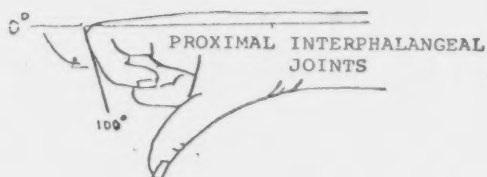
RIGHT HAND

2 3 4 5



LEFT HAND

2 3 4 5



RIGHT HAND

2 3 4 5

LEFT HAND

2 3 4 5



RIGHT HAND

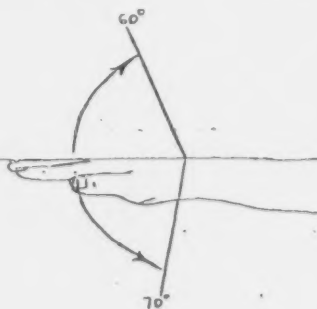
2 3 4 5

EXTENSION AND FLEXION OF THE WRIST

LEFT WRIST

EXTENSION 60°

0°

FLEXION 70°

RIGHT WRIST

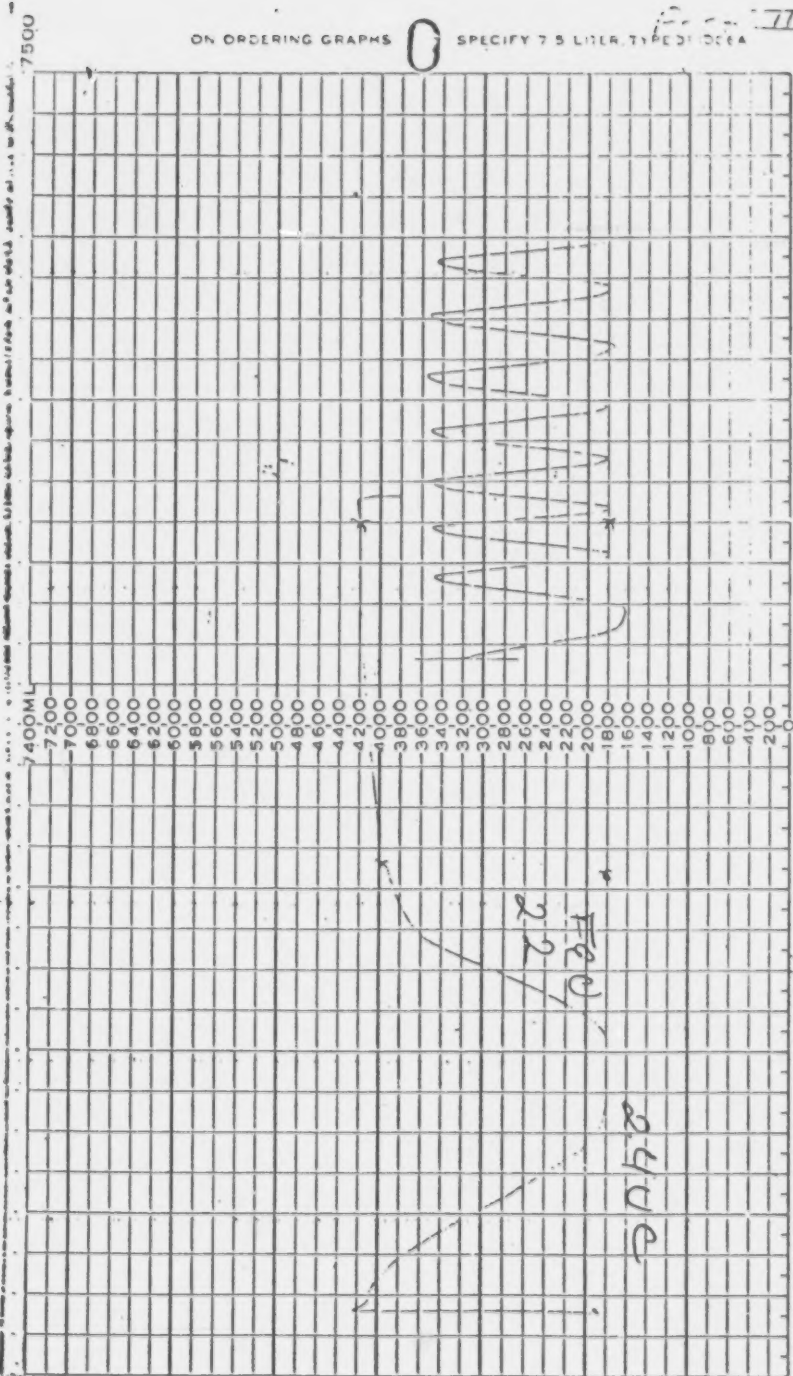
EXTENSION 60°FLEXION 70°

JAN 21 1981

ON ORDERING GRAPHS

SPECIFY 7.5 LITER, TYPE D1000A

POST 2



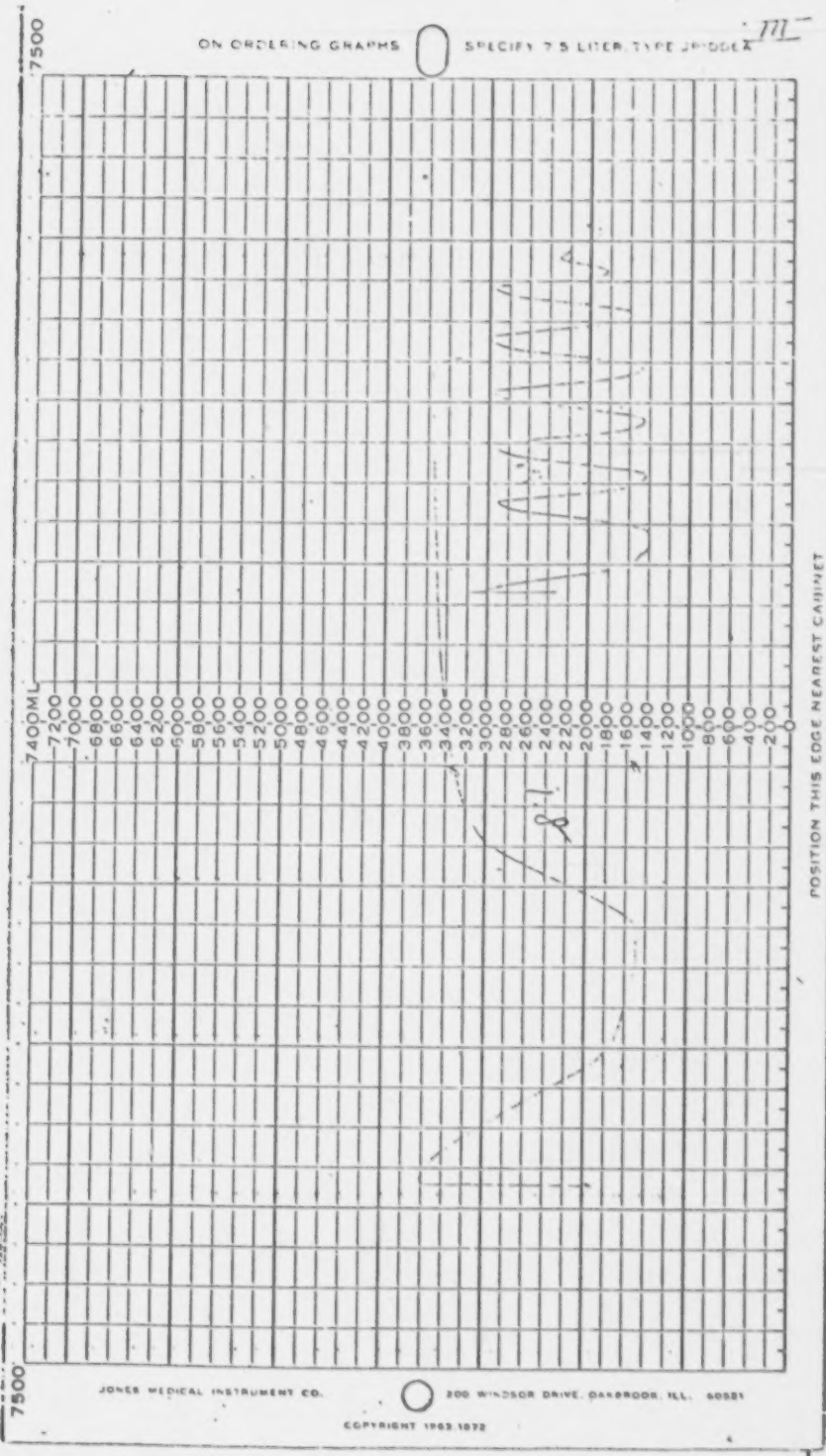
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POST-3



ON ORDERING GRAPHS

SPECIFY 7.5 LITER TYPE JF1026A

3 PRE.

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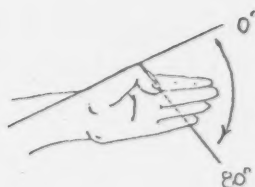
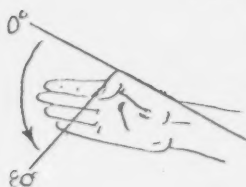
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Flexion of the Thumb

Fill in only if abnormal



Zero starting position



Interphalangeal joint



Metacarpophalangeal joint



Carpometacarpal joint

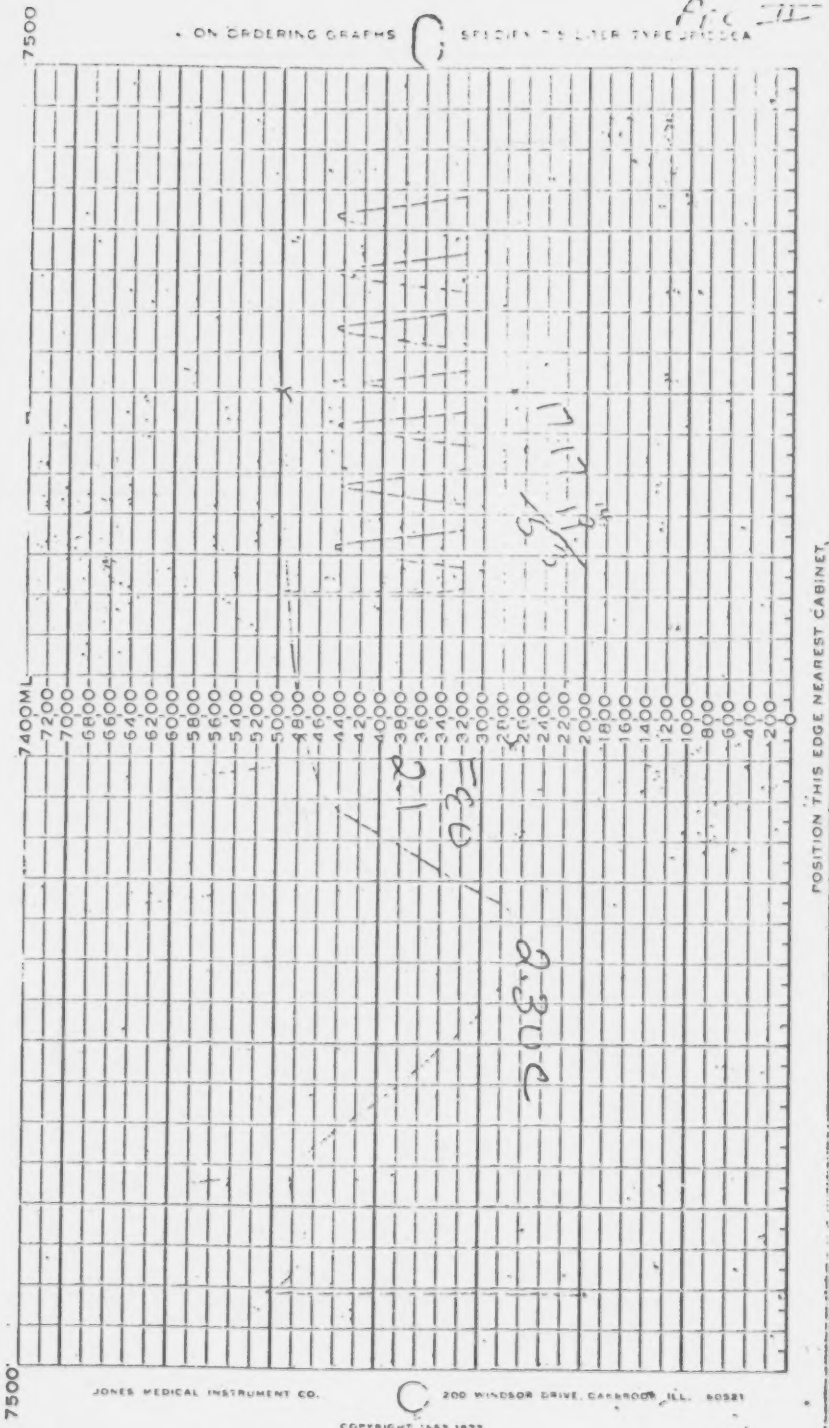
Right

Left

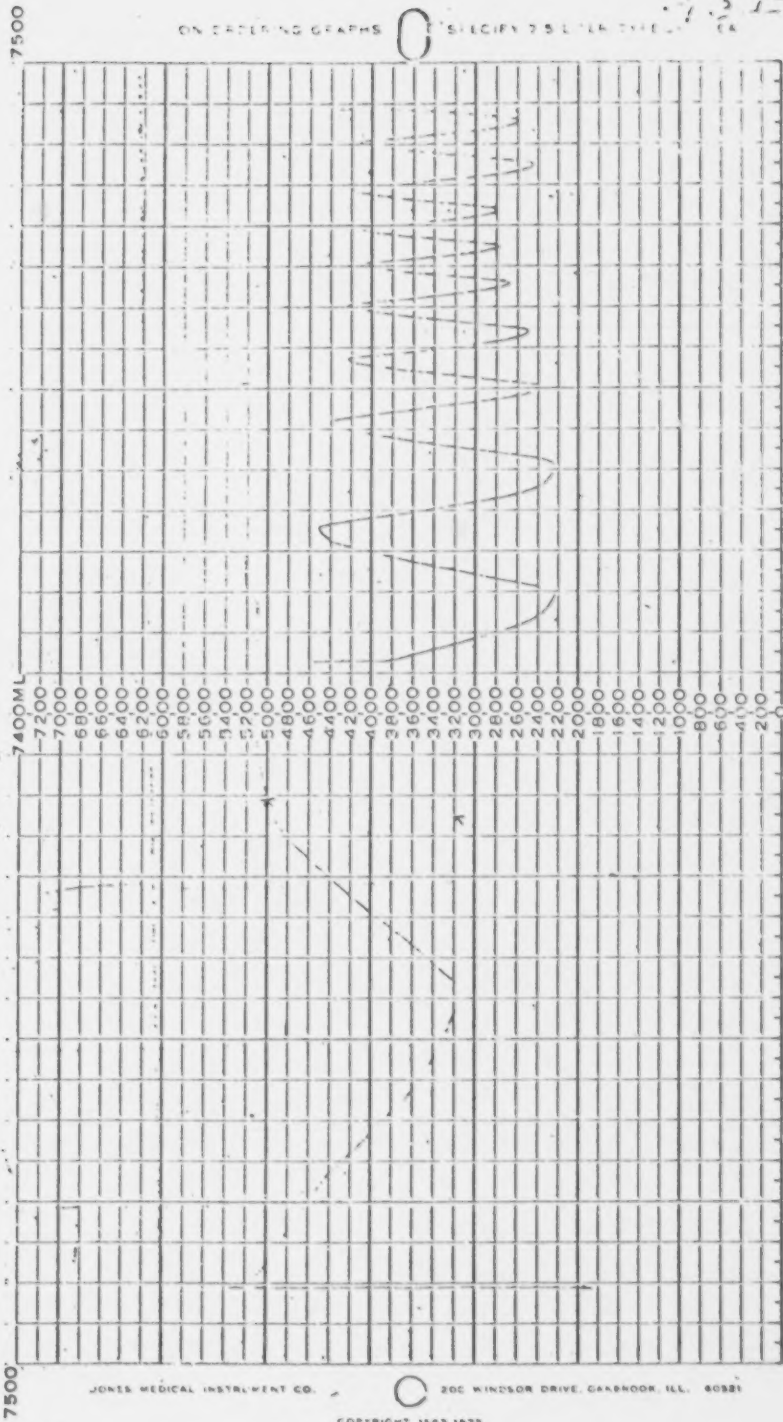
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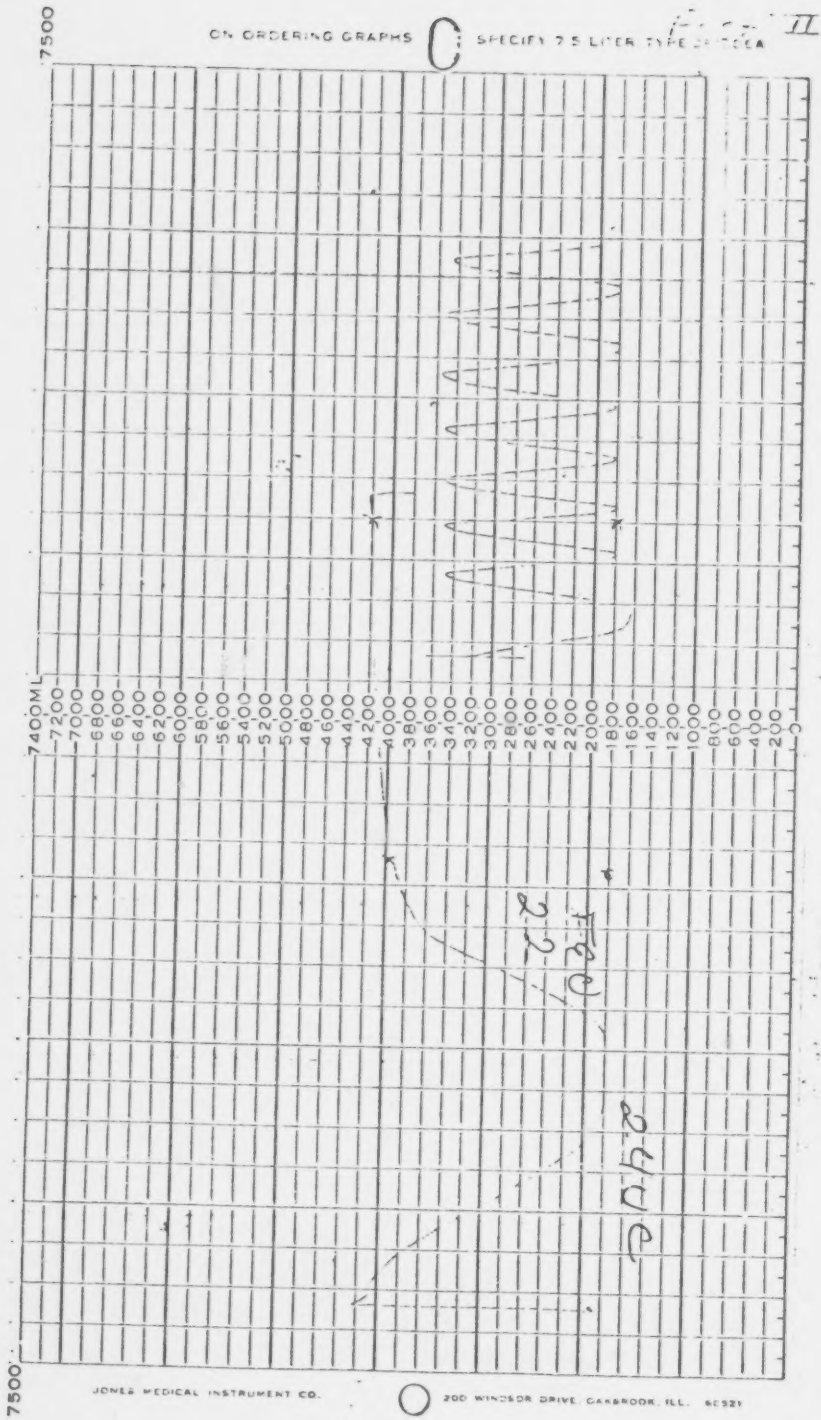
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POSITION THIS EDGE NEAREST CARINFT

POST-2



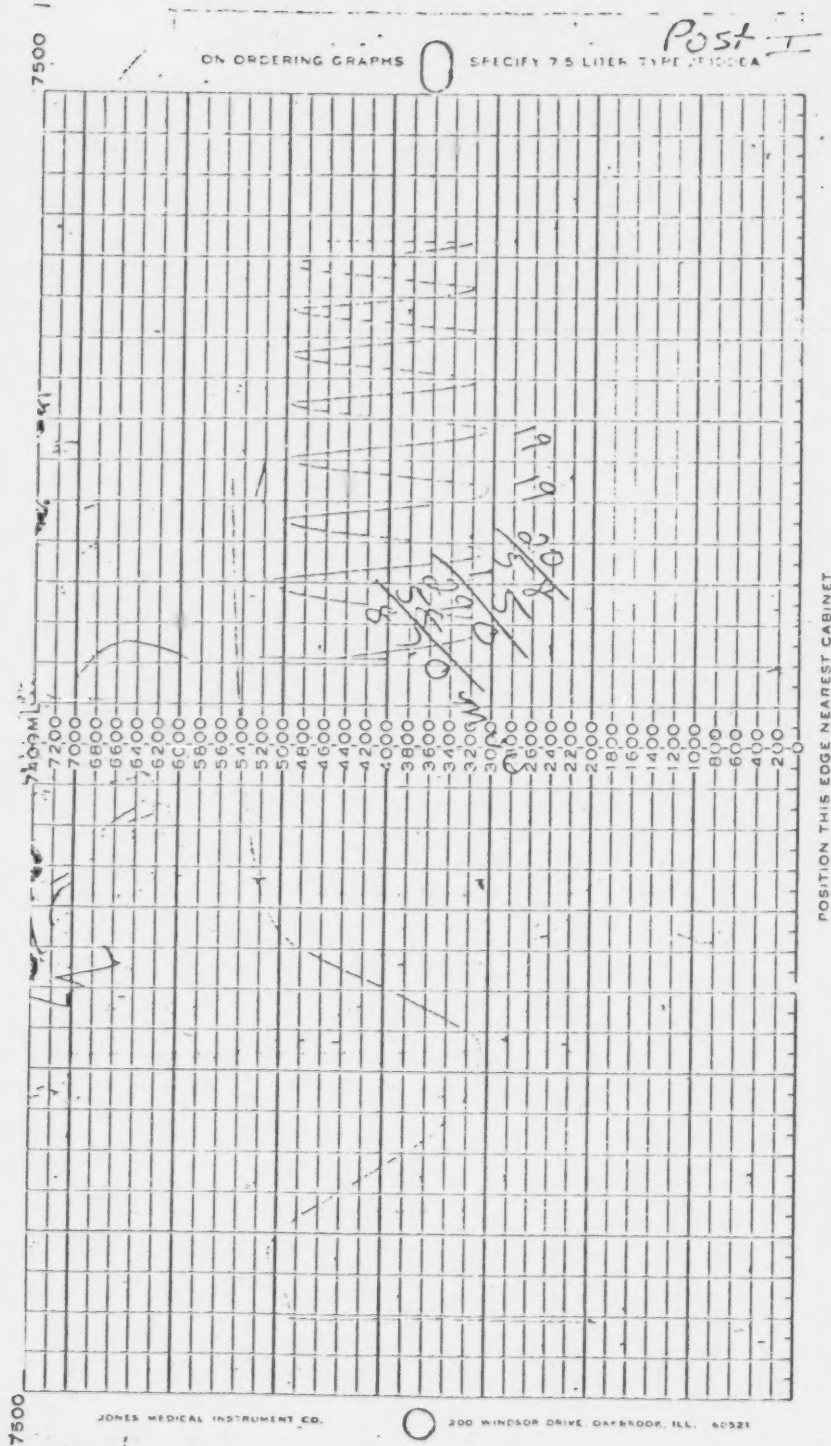
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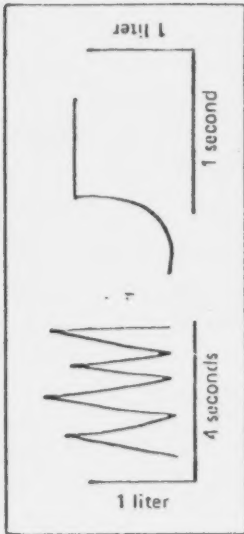
200 WINDSOR DRIVE, GAYBROOK, ILL. 60521

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NAME Burton, Tina
 DATE 1/15/84
 HEIGHT 61" AGE 51

Best Attempt:

	Pre	Post
FEV ₁	2.1	2.2
MVV	82.5	87.0
VC	2.3	2.4

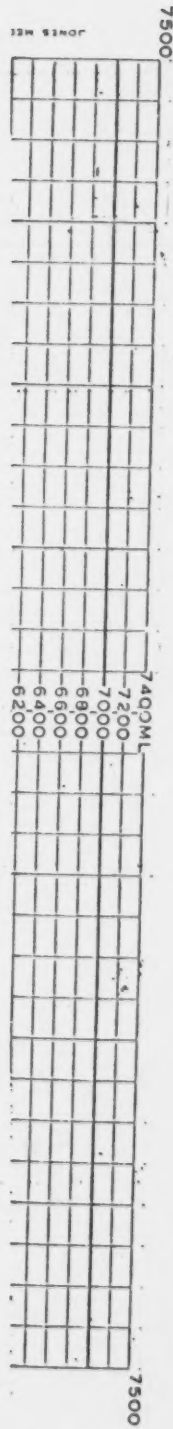


On the horizontal axis, 1" equals either 1 or 4 secs. On the vertical axis, 1" equals 1 liter.



SUBURBAN INTERNAL MEDICINE GROUP

JAN 21 1984



1 PRE

J.D. Burns, being first duly sworn, deposes and states as follows:

I am J.D. Burns, 56 years of age, and I reside at 223 Cherry Street in Franklin, Tennessee. I have worked practically all of my life since I was 9 years old, most recently being a Deputy Sheriff, rank of Sergeant, with the Williamson County Sheriff's Department. I have not been able to work since the Spring of 1979 due to a recurrent retroperitoneal abscess in the right flank of my lower back. This abscess has been draining, almost continuously from the Fall of 1978 until about the middle of 1981. The draining started shortly after I had a cholecystectomy, which was a removal of my gallbladder in the early Fall of 1978. I have been hospitalized seven (7) times during the past three and a half years for surgical procedures connected to this draining abscess in my back, including the removal of my right, eleventh and twelfth ribs in the Summer of 1980. Throughout this period of time I have also had extreme difficulty engaging in any sustained physical activity because I run out of breath so quickly.

I applied for Social Security Disability and Supplemental Security Income benefits and was awarded such benefits in June, 1980, with an onset of disability date established in May, 1979. I received disability benefits until June, 1981. I was notified by letter of April 6, 1981, that my benefits were being terminated because it was determined that I was no longer disabled as of March, 1981. One week before the date of my termination notice, I was examined by Dr. Stephen S. Thurman at the request of the Social Security people. Prior to terminating my benefits, they did not send me to any other doctor or consultant for any reason with the exception of a doctor I was sent to back in the Fall of 1979, before I was awarded benefits. I do not remember that

doctor's name but I was sent to him by Social Security and he did do a complete physical examination of me in the Fall of 1979.

The report by Dr. Thurman which is attached to this Affidavit was obtained by my attorney on January 27, 1982, at the time we had my hearing before the Administrative Law Judge. The report apparently concerns Dr. Thurman's examination of me on March 30, 1981. I have not seen Dr. Stephen Thurman but once in my entire life and that was on March 30, 1981 at the time he examined me. To my knowledge I have not spoken to any associate, employee or agent of Dr. Thurman's with regard to any matter connected to my examination of March 30, 1981 by Dr. Stephen Thurman. I did not see his report, dated March 31, 1981, and addressed to Ms. Gloria Conley, Disability Determinations Section, or know anything about its contents until I was shown the report briefly by my attorney on January 27, 1982.

I was accompanied to Dr. Thurman's office by my wife and a friend who drove us there for the appointment. I told the person behind the front desk why I was there and was told they were expecting me and that I should have a seat and would be called shortly. No one spoke to us while we were waiting in the waiting room. I was called back to the examining room a short time later and my wife and friend remained in the waiting room. I was ushered into an examining room where a man was waiting for me and he introduced himself as Dr. Stephen Thurman. I introduced myself and told him that my treating physician, Dr. David Morgan, had told me to ask Dr. Thurman to give him a call so that he might discuss my case with Dr. Thurman. Dr. Thurman's reply surprised me quite a bit in that he bluntly replied, "I am a doctor and I do not have to speak to any other doctor about this". During the entire examination Dr. Thurman and I were the only persons in the room. I observed no recording instrument of any type and I did not observe Dr. Thurman writing down anything. Dr. Thurman told me to take off my coat and shirt but leave my t-shirt on. He then instructed me to climb up on the examining table and lay on my

stomach. During the entire examination I remained fully dressed with the exception of removing my coat and dress shirt as well as slipping my loafers off, when I climbed up onto the examining table. As Dr. Thurman began to remove the large amount of dressing material within and surrounding my abscess wound, I begged him to again call Dr. Morgan so that he might more fully understand what is involved with the wound. His removing of the dressings was causing me a great deal of pain. He responded again that he was a doctor and knew what he was doing and did not have to talk to anybody else about this. Previously, whenever my wound area was to be examined by a doctor, I would receive a pain shot or a pain pill to help me endure the examination. I received nothing of this nature before this examination. Dr. Thurman then inserted an instrument, which I suspect was a long q-tip into my wound and began probing around the abscess. The pain was excruciating during this period of time and I cannot fully remember how long he was probing in the wound area for that reason. However, I could tell when he was finished examining the wound and had removed the instrument from it. I believe my wound was particularly sensitive and painful during this examination because a build-up of discharge and infection was probably beginning to occur at this time and it culminated in my having to re-enter St. Thomas Hospital on an emergency basis in less than two weeks time so that the abscess could once again be drained and surgically explored.

When Dr. Thurman finished probing around in my wound he told me that the examination was over and I could leave. He had not replaced any of the dressing or drainage tubes in their proper position and I asked him if he would do that. He replied that the examination was over and he was finished with me and at that he walked out the door. I remained on the examining table hoping that someone would come to my assistance. A nurse entered the room and told me that I was now free to get dressed and leave. She then left the room. I slowly put my shirt and coat back on as best I could and proceeded to the waiting room where I told my wife that none of the dressings or tubes had been properly replaced.

After we left Dr. Thurman's offices she proceeded to properly dress the wound area and position the drainage tubes.

Contrary to what is written in his report, Dr. Thurman's examination of me on March 30, 1981, consisted entirely of what I have just related in this Affidavit. He did not question me at all about my past history, medical and otherwise, nor about my present daily routine, habits, family problems, physical or mental problems, or any other aspect of my present circumstances. At no point was my blood pressure taken by Dr. Thurman or anyone connected with him. Nor was my height nor weight measured. In fact, I am not seventy-one (71) inches tall as stated by Dr. Thurman, I am seventy-four (74) inches in height. At no point did he or anyone else from his office physically examine or even appear to visually examine my head, neck, eyes, ears, nose, throat, heart, lungs, peripheral joints, abdomen, extremities or neurological senses or reflexes. No instruments, including a stethoscope, were used in any way by Dr. Thurman during the examination, with the exception of the instrument he used to probe around in my wound.

During the past three and a half years of hospitalizations and various medical examinations I have become quite familiar with many basic medical procedures. I am fully aware when x-rays, electrocardiograms and pulmonary functions studies are being made of me. There is no doubt that neither Dr. Thurman nor anyone under his authority conducted any x-rays, electrocardiograms or pulmonary functions studies on March 30, 1981, or at any other time.

Since my Social Security benefits stopped coming as of June, 1981, my family has suffered greatly for want of the finances necessary to pay for even the basic necessities. We have fallen behind in making the low monthly payments on our house and have had to borrow and accept gifts from friends in order to stay in it this long. I have also been unable to purchase pain and other necessary medication because I am no longer covered by Medicaid and do not have any other money to buy these items.

We have all gone without many household and other personal items that we have been used to having all our lives. Because of our desperate situation, I wish more than ever that I could do some type of work. But I know that I am simply unable to physically engage in any activity that requires any type of exertion for more than a few minutes at a time. I remain hopeful that my benefits will be reinstated.

FURTHER AFFIANT SAITH NOT.

J. D. Burns
AFFIANT

Subscribed to and sworn before me,
this 35th day of January, 1982.

Cheryl L. Vantrease
NOTARY PUBLIC

My Commission Expires:

10/21/84

SUBURBAN INTERNAL MEDICINE GROUP

March 31, 1981

Ms. Gloria Conley
 Disability Determinations Section
 1808 West End Building - Ninth Floor
 Nashville, Tennessee 37203

JAN 30 1981

RE: BURNS, J. D.
 410-36-5380

Dear Ms. Conley:

I would like to thank you for referring Mr. J. D. Burns to our office on March 30, 1981 for his medical evaluation. This 55-year-old gentleman with an eighth-grade education last worked in 1979 as a Sergeant with the Williamson County Sheriff's Department.

Mr. Burns had a cholecystectomy in September of 1978, and I think related to this has had a retroperitoneal abscess that has drained since 1978. As a matter of fact, every time the drainage and sinus tract closes down, he will develop fever and become quite toxically ill. I doubt if this will ever be resolved while he lives. I have seen patient's who have lived with this for forty years. President Jackson had a draining abscess for many years. The best thing to do for this is just to keep it draining so that the purulent discharge is not obstructed.

This man complains of shortness of breath on walking one-half block on the level or up one-half flight of steps. He sleeps with two pillows, but has no swelling at all of his ankles. He has been short of breath for the last four years. He has some wheezing and asthma, but no chronic sputum production.

Also for the last four years, he has been having a pressing type of pain three or four times a month on the left side of his chest. This lasts for about an hour at a time. It is related to exercise, and relieved by rest. He had a treadmill test last year. He does not take nitroglycerin. There is no history of a heart murmur, rheumatic heart disease, or a heart murmur.

Past Medical History:

This reveals attempts to keep the drainage open or attempt to heal it. He had a growth removed from his right eye back in 1970. I think this was a pterygium. One is beginning to form on the opposite eye, but is not yet significant.

Social History:

APR 3 2 1981

EXHIBIT 15 (14)

BURNS, J. D.
March 31, 1981
Page -2

He smokes about one-half pack a day of cigarettes, but does not drink alcohol at all. He is followed by Dr. David Morgan, Dr. James Haynes, and Dr. Allen Kaiser.

Review of Systems:

He has no problems related to a prior heart attack or stroke, liver disease, ulcers, his nerves, back pain, peripheral arthritis, cancer, diabetes, or high blood pressure.

Physical Examination

Blood pressure (right arm): 140/90	Height: 71 inches
Blood pressure (left arm): 140/90	Weight: 240 pounds

Mr. Burns is a very large-appearing gentleman with a deep scar over his lower right flank. There is a sinus tract that is draining purulent discharge even at this very point in time. This looks like it should cause him some discomfort. It is a very chronic-appearing process.

Head - the cephalic dimensions are proportionate to the rest of the body. There is no significant sinus tenderness.

Neck - nuchal rigidity was absent. Cervical examination revealed no significantly enlarged lymph nodes. Distention of the external jugular veins is not visible when Mr. Burns sits up.

Eyes - The patient has a moderate pterygium forming on the inner aspect of the left eye. This has not seriously affected the cornea yet. The fundoscopic examination is benign.

Ears - no limiting exudative discharge was brought to light by otoscopic examination. Hearing was not seriously decreased as evidenced by the ability to understand a conversation at six feet. Congenital deformity is not evident of the ears.

Nose - no pathological process has damaged the nasal septum substantially. Detectable epistaxis is not evident.

Throat - glossal fasciculation could not be discerned. The soft palate is not deviated to the right or to the left.

Heart - the first and second heart-sounds are normal. There are no murmurs or palpable cardiomegaly.

Lungs - respiratory effort is not labored. The lung fields are clear for rales or bronchoconstriction. No rub was clinically appreciable.

Peripheral joints - the patient has scars over the right shoulder from past surgery. This is really more into the pectoral region. He has only eighty degrees of abduction remaining in the right

BURNS, J. D.
 March 31, 1981
 Page -3

shoulder. There is no evidence of instability, however. There is no evidence of active inflammation.

Back - Mr. Burns has the large scars around the still-draining sinus tract over the right flank. It is uncomfortable for him to laterally flex more than ten degrees to the left because of this problem on the right. Extension is also uncomfortable for him. This will keep him from doing heavy physical activities.

Abdomen - the abdominal viscera are not involved by masses. Neither an increase in the hepatic span nor a palpable spleen was evident. Ascitic fluid has not accumulated in the abdominal cavity.

Extremities - the ankles and calves are not edematous. The nailbeds are not cyanotic or clubbed.

Neurological exam - Mr. Burns was adequately coordinated. The arms and legs had good strength, coordination, and sensory ability. The cranial nerves and the deep tendon reflexes were intact upon examination.

LABORATORY DATA:

The chest x-ray reveals a normal CT ratio of 14.5/35 centimeters. The heart is not enlarged. The chambers appear normal.

Electrocardiogram - This reveals left axis deviation. There is a sinus rhythm of 108 per minute. The P-R interval is 0.16, the QRS interval is 0.07, and the Q-T interval is 0.30. The electrical axis is -30° .

The pulmonary functions are done with intelligence and vigor. Although there is some obstruction to air flow consistent with early chronic obstructive pulmonary disease, there is no critical loss of pulmonary reserve. On the vertical axis, one inch is equal to one liter. On the horizontal axis, one inch is equal to either one second for the vital capacity or to four seconds for the maximum voluntary ventilations. These studies are done with good understanding and good cooperation. The forced expiratory volume for one second (FEV₁) is 1.4 liters pre-Isuprel and 1.8 liters post-Isuprel inhalation. The maximum voluntary ventilation (MVV) is 67.5 liters pre- and 69.0 liters post-bronchodilators. The forced vital capacity (VC) pre-Isuprel is 2.2 liters and post-Isuprel is 2.5 liters. There is an adequate pulmonary reserve present here. With this pulmonary reserve, there would appear to be no significant decrease in physical capacity secondary to any sort of decrease in pulmonary reserve.

Views of the right shoulder done additionally in view of the pain and decreased range of motion reveal the glenohumeral joint space to be well preserved. There is no evidence of unhealed fracture. There is no evidence of osteoporosis. There is no evidence of cortical erosion.

APR 02 1981

BURNS, J. D.
March 31, 1981
Page -4

IMPRESSIONS:

1. Chest pain

The cardiograms done today are nondiagnostic. I can find no documentation of a recent myocardial infarction. This description of his chest pain does not sound like angina.

2. Shortness of breath

There is some early chronic obstructive pulmonary disease on the pulmonary function studies, but there is no critical loss of pulmonary reserve. There is no evidence of heart failure either. There is no cardiomegaly or pedal edema.

3. Recurrent retroperitoneal abscess

This is still draining through his sinus tract into the right flank. This diminishes the range of motion of the back somewhat. This would limit him to moderate physical activities.

4. Old injury to the right shoulder

He does have a diminution in the range of motion of this shoulder. However, he has got good use of his arm, forearm, hand, and wrist. This would still allow him to do moderate physical activities.

PHYSICAL CAPACITY EVALUATION:

This gentleman who is a very large and substantial man is limited to moderate physical activities at this point in time.

Yours very truly,



Stephen S. Thurman, M. D.

SST/fr

STATEMENT OF JOHN VAIL, LITIGATION DIRECTOR, LEGAL
SERVICES OF UPPER EAST TENNESSEE, INC.

Mr. VAIL. Thank you, Congressman.

We have both submitted prepared testimony. We would like that to be included in the record.

Chairman PICKLE. Make sure whatever information you have is submitted. It will be made a permanent part of the record.

Mr. VAIL. I talk about a couple of things here. I practice law in the northeastern part of Tennessee, in a rural area, a great part of the world but tremendously medically underserved. I represent poor people. I have counties that have less than one doctor per 3,500 people, and that one does not take medicaid. So this problem with volume providers of consultative examinations has a particular impact on these people, because they seldom have treating physicians. They are much more likely to be referred for a CE.

What I wanted to talk about mostly today was the secretary's attitude about this thing, and talk about the investigation the secretary did make of the Thurmans. I am familiar with the Thurmans through my practice. I moved there in November of 1980. It seemed that all of the claimants' representatives have their favorite Thurman stories. I said, what's up, what is this? I started to see the same things. We started to talk about it internally and informally organize. Then, boom, there was the *Lindgren* case in Virginia, the ruling of fraud. The Thurmans were all over every newspaper in the State.

So, we knew that something was up. We knew we had a systematic problem on our hands. We knew if we litigated it it would be expensive, it would be protracted, so we went to the DDS and Social Security. Yes, we brought our problems to them first. They talked about that. They said, well, bring them to us. We went.

Wednesday, July 29, we had a meeting with several claimants' representatives, Herb Brown, the chief of Tennessee DDS, and Tom Read, the district manager in Nashville for Social Security. These things are referred to in your previous subcommittee documents.

This meeting takes place during the time the Thurmans are suspended. They have already been suspended, but they have not been reinstated. We meet with these folks, and we make some suggestions about what they should do. We say, you should get some disinterested experts together, some people who know some medicine, to review these things. We said, you should publicize this, let people know what is happening and what you are doing.

The Social Security should let people know they are doing something, because the perception of fairness, and, we think, the fairness itself, of the disability adjudication system is suffering. It is something people are not trusting any more, in large part because of this, and it is very important to any system of adjudication. We say, give everybody a chance to talk. Hold some hearings. Let claimants come in. Let us talk. Let the examiners talk. Let the ALJ's talk. Let the consultative examiners talk themselves. Have it good, something reliable.

We also said, have an ombudsman so you can get in and out of the investigation fast. You can find out who to talk to.

Now, this seemed to us to be a proper response, because in the last year you have paid \$1 million to these people, and they have been found—this is not an allegation—they have been found by a Federal court to have been propounding fraudulent testimony.

Now, the interesting part about this is, Mr. Read agrees. Mr. Read is the Social Security Administration official closest to everything that is happening. He sends a memo to Atlanta. That memo is attached to my testimony. He notes that we will offer to serve as contact for the investigation. This offer was made clear, that they would try and not present a one-sided picture, but since many of the claimants they represent on a continuing basis, et cetera, they would be good people. He concludes his memorandum by saying, "it is my considered opinion that these individuals are sincere in their concerns and that they can and will pursue the matter in a fair and timely manner."

It would seem to me that where we have the latitude and opportunity to cooperate, we should continue to work with this organization—being us, with us—since it would be in the best interests of the public and the Administration to do so.

He concurred in that, and what did you get from the Secretary, from the people who sit in Baltimore? Well, they send out teams of three people to each of three States to talk to the DDS officials. Well, Read has already told them, and they should know by now that we are more feisty than that. That is not going to be something to placate us. And that is all it could have been designed to do, to placate, because it was not going to find out anything.

Sandy Crank was here and testified, and he said, and the people of Tennessee said, our investigation did not go behind the pieces of paper that come in, the four-page Thurman report. Well, I will say it, too. For the genre, it is beautiful. It is four pages. It is neat. The words are spelled right. The grammar is tolerable. I could write you a four-page legal brief that cited all kinds of legal cases on point, and you would not know until you went into the library that I had made up every legal case in there.

That is the same kind of problem you have here. The Secretary's investigation did not answer anything about the allegations. You have a couple of pretty important newspapers in this country who have been very embarrassed the past year about doing the same kind of thing, not going behind and checking what actually happens.

That, I think, was crucial. That investigation was not worth very much.

Congressman Pickle asked before who schedules the consultative examination. That is very important. In Tennessee, at least, let us look at what actually happens. Your are a claims examiner, you work at DDS. The decision about whether to schedule a consultative and to whom is yours. So you are the person sitting there. Now, your personnel evaluations depend on it. The single most important factor is how closely you come to hitting your time targets. You get a Thurman report back on an average of 12 days. You get a different CE report back on the average of 24 days.

This is one thing where the Thurmans have done very well. They have geared their system to do that, and they take advantage of a bias. It is not a bias of bad integrity. It is just, face it, if you were

sitting there, you had the choice, you have a 12-day advantage one way, you are more likely to get a pay raise, you are going to send it to the Thurmans. So, that is another reason why talking to the DDS people was to some extent suspect.

You are talking about the delay, too. I realize the committee is sensitive to delay. Nobody is more sensitive to delay than claimants, because those are the people who suffer the most from delay, but my clients are willing to wait an extra day, spend an extra dollar to get something that is worthwhile, to get something they can trust.

Marty Wegbreit alluded to another problem. You get a Thurman report. It is not signed by the doctor. You know that was a tremendous problem, because that is not even legal under *Richardson v. Perales*. The thing cannot be evidence if it is not signed by the examining physician. So what they do is they send the thing out to the examining physician.

By this time you are sitting around in your office with a cupcake with a candle in it, having a first birthday party for this report, because it is already 1 year old, and they say: You did not sign this. Go ahead and sign it. And of course they do. They send them back.

Now you tell me. There are a lot of lawyers here. These people have seen 25 to 35 people per examination day over the past year. What kind of independent recollection do they have about that report? Do they know anything about it? If they can, I would be amazed.

Another important point is, the Social Security Administration has to rely in its defense of the process on a survey of the Thurmans done by the Tennessee DDS. Now, that survey is unreliable for several reasons. When that survey was done, there were in effect quality assurance standards for how you go about doing a survey, a piece of survey research, so that it is reliable. Those standards were admittedly not even attempted to be followed in the survey of the Thurmans.

Tennessee DDS generated a sample by sending out questionnaires until 100 came back. That is not random. It is not reliable. And it has systematic biases against poor people and against illiterate people who are much less likely to send one of those things back.

I have made here several recommendations about what can be done. One of the things we see as a problem is that nobody verifies that the medical assistants upon whom the volume providers rely very heavily know anything about what they do. In fact, in the Thurman cases, it seems that in many cases they do not. Nobody knows whether the person taking that X-ray knows a Roentgen from a Rastafarian. They do not know this. They do not oversee it. Know, too, that there are not market incentives here to make these people perform well, because any malpractice liability is very questionable at best. These people specifically disclaim any physician-patient relationship with the claimants they see. So one of the things we have said is, set standards for those people. Require the volume providers to certify that the people meet the standards under penalty of perjury. You cannot legislate the fear of the Lord, but you can legislate the fear of the criminal justice system. Allow recovery of treble the amount that you paid them to do the exam if

those things are not met. I think that has the advantage of being a system that is easily enforced, not expensive to administer.

The same goes with medical equipment. We have found with the Thurmans that it is a traveling medicine show. Some of the X-ray—at least one of the X-ray machines they used was not designed to be taken up and put down, and could not withstand that kind of thing.

We have asked them to certify that everything about this is made with their personal knowledge, personal knowledge being something that there has not been much of in the Secretary's investigation of this thing, or at least from knowledge that is the kind people rely on in the profession, laboratory reports, et cetera.

We have asked also that when you have a consultative examiner, you require that they respond to interrogatories from claimants. You have discretionary authority for an ALJ to subpoena a CE. It is very hard to get him to use it, because it is very expensive. They have to pay travel fees, they have to pay time. So, interrogatories seem a good compromise.

A particular class of people I need to mention who are getting impacted very much here are title II recipients who are the subject of CDI exams. Sandy Crank estimates that 75 percent of these people will see consultative examiners. If you have an erroneous piece of evidence in a case like that, the person can be cut off from benefits before they have any effective chance to rebut. You can cut those people off without a hearing under *Mathews v. Eldridge*. I would suggest legislation to require pre-termination hearings at least for that class of people, because they face a grave danger of being victimized by going without benefits without any effective chance to put on their case.

We will both field questions.

[The prepared statement follows:]

STATEMENT OF JOHN VAIL, ESQ., LITIGATION DIRECTOR, LEGAL SERVICES OF UPPER EAST TENNESSEE, INC.

This statement is on behalf of Bessie Dixon, Mamie Giles, Georgia Grindstaff, Ruby Mae Harper, Linnie Mae Lloyd, Frances Slempp, Lydia Benson, George Birchfield, Robert Davenport, Ralph E. Davis, Samuel W. Horton, Eugene Rollins, Boyd L. Bryant, Albert W. Dennis, Henderson Dukes, Kenneth E. Hammett, Claude E. Hensley, Clarence Hicks, Beatrice Taylor, and James Cloyd.

SUMMARY

1. The use of high volume consultative examiners has given rise to systematic unfairness in Disability adjudications.
2. The poor are particularly victimized by the problems with high volume consultative examiners, as they are more likely to be referred to them and less likely to be able to rebut their findings.
3. Title II Disability recipients who become the subject of continuing Disability investigations are also particularly victimized, as consultative examiners are expected to be used in 75 percent of these cases and the recipient faces termination of benefits without any opportunity to rebut the consultative report.
4. The Administration rejected a rational plan for investigating the Suburban Internal Medicine Group and conducted a wholly inadequate investigation.
5. Primary responsibility for regulating high volume consultative examiners should be with the Social Security Administration, which should require:
 - (a) Minimum times for examinations.
 - (b) Competent paraprofessionals.
 - (c) Serviceable medical equipment.
 - (d) Certification by examining physicians of the truthfulness of the reports.

- (e) That consultative examiner's respond to claimants' interrogatories.
 - (f) That evidence be purchased from consultative examiners only if treating or local physicians are unavailable.
6. By legislation, Congress should require pre-termination hearings for Title II recipients subject to CDI reviews.

STATEMENT

I thought time would best be served if I addressed today only one aspect of the volume providers issue: what roles must Congress, the Secretary, and the State Agencies play in regulating volume providers? I will describe the Secretary's response to allegations of problems with the Suburban Internal Medicine Group, a/k/a Thurman & Thurman; show that the response was inadequate, revealing a distressing lack of concern with the quality of consultative examinations; and show why, under the Continuing Disability Investigation (CDI) Program mandated by the 1980 amendments, the problem is particularly egregious.

Before I begin my described task I would note that I, too, could bring a parade of horrors to the Committee. I do not only because I know that the suffering will be described adequately by others. I mention my choice because I do not want an inference made that because I did not talk about them, they are not there.

I practice law in the twelve (12) rural counties which comprise the northeastern tip of Tennessee. There is no city of greater than 50,000 persons in the region and the region is woefully medically under-served, some counties having less than 1 physician per 3,000 persons. Citing difficulty contracting with local physicians, the Tennessee DDS relied heavily on a Suburban Internal Medicine Group Office in Kingsport, Tennessee, to provide consultative examinations to Disability claimants in this region.

I spend approximately twenty-five percent (25%) of my time representing people in Disability matters and have litigated some of the cases you will hear mentioned today. I also oversee a corps of paralegals and attorneys involved in this kind of representation.

I began practicing where I now do in November of 1980. Even then the Suburban Internal Medicine Group was a topic of lively discussion among claimants' representatives. It seemed that everyone I met had their favorite Thurman horror story.

The public eye focused on the Thurmans after the ruling of fraud in *Lindgren, et al. v. Schweiker*, U.S.D.C. for the District of Virginia, Big Stone Gap Division (Civil Action No. 81-0039-B). Claimants who had had problems with the Thurmans found suddenly that they were hardly alone. Discussion among their representatives became more organized.

In an effort to avoid what we considered would be protracted and expensive litigation, other representatives and I took our clients' complaints to the Social Security Administration and the State DDS, hoping for a quick solution.

On Wednesday, July 29, 1981, several other claimants' representatives and I met with Mr. Herb Brown, Director of the Tennessee DDS and Tom Reed, District Manager for Social Security in Nashville. This was during the suspension of the Thurmans from performing consultative examinations. At that meeting, claimants' representatives made several suggestions about how an investigation of the Thurmans should be performed. Among these suggestions were: that disinterested experts be assembled to conduct the investigation; that the investigation be publicized; and that all parties touched by the issue—claimants, claimants' representatives, employees of the State DDS offices, ALJ's, and the consultative examiners, themselves—be allowed to testify. We also proposed that an ombudsman be assigned to provide both access to the investigation and accurate information to anyone who might inquire. The claimants' representatives offered their services in coordinating testimony from their clientele. The suggested response seemed proper, as an entity to which the Administration paid on the order of \$1 Million in 1980 was found by a Federal Judge to have been providing fraudulent reports.

Mr. Reed, the agent of the Secretary closest to the problem, concurred. In a Memorandum to the Regional Disability Programs Branch on July 30, he concluded that it would be in the best interest of the public and the Administration to adopt these suggestions. That Memorandum is attached as Exhibit A to my testimony.

The suggestions of Mr. Reed—and of claimants' representatives—went unheeded. The Secretary did, indeed, conduct an "investigation." Its results are available to you at Appendix D of the September 18, 1981, Subcommittee document on this issue. In referring to the investigative report, I will give page numbers as they appear in the Subcommittee document. Basically, the Secretary sent teams of three (3) persons to Georgia, Tennessee, and Virginia, to talk with employees of the State DDS Of-

fices. Regardless of the integrity of those involved, which I do not question, so aloof an investigation answers nothing.

First, we must note the bias of DDS employees. Especially since implementation of the 1980 amendments, the DDS Offices are swamped with work. To the Disability Examiner who schedules consultative examinations, time is of first importance. In Tennessee at least, the primary criterion in personnel evaluations of DDS employees is how close they come to hitting time targets. The Thurman operation took advantage of this bias. Where most doctors took over three (3) weeks to get a report of an examination to the DDS, the Thurmans took less than two (2). As an individual examiner whose pay raise depends on how fast cases get processed, this could easily be a deciding factor in deciding from whom medical evidence would be purchased. This would be a systematic bias against purchasing medical evidence from those from whom, according to Sandy Crank, Associate Commissioner for Operational Policy and Procedure, Social Security Administration, in his September 18 testimony to this Subcommittee, it is most preferred: the treating physicians. Of course, the effect is felt most by persons too poor to purchase their own medical evidence.

No one has a greater interest in rapid processing than claimants. However, claimants are not served by small gains in time bought with large sacrifices in quality.

This concern with processing time was made clear in an August 14 meeting between claimants' representatives and SSA and DDS personnel. When asked whether a doctor had ever been suspended for low quality examinations, government employees couldn't remember whether any had, but noted that doctors had been suspended for not getting reports back on time.

Second, the investigation did not go behind the faces of the reports themselves. This is admitted by Mr. Crank and it is critical. No one has ever complained that a Thurman report was inadequate. Indeed, for the genre, it's a beauty for the eye to behold: four (4) pages of programmed language in standard format, spelling correct, grammar tolerable. The complaints have been about discrepancies between what happened in the office and what appears on the report. After the Secretary's investigation, we are no more enlightened about this than we were before. Mr. Ed Reece, Assistant Commissioner of Education for Tennessee with responsibility for overseeing the DDS, at the August 14th meeting joined this criticism and expressed concern that quality assurance in DDS is based on the printed page, not on what occurs during examinations. The Secretary's Investigative Report is almost devoid of testimony from people with personal knowledge of Thurman examinations. The kind of evidence you hear today surely requires scrutiny of office practices, not printed pages.

Third, inadequate as it is, the investigation shows serious problems. It noted the problem of canned language which can show claimants of very low I.Q. to be bright, alert and cooperative, or report demonstrably incorrect height. (31). One Georgia examiner who had also worked in Tennessee said she never used the Thurmans because she had received complaints about them and because their reports sometimes contained discrepancies that had to be resolved by further consultative examinations. (30). Virginia DDS, though ostensibly monitoring the Thurmans, never detected a systematic problem of reports not being signed by the examining physician, a practice rendering the reports useless as evidence under *Richardson v. Perales*, 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed2d 842 (1971). See also *Collins v. Schweiker*, (No. CIV-2-81-92, ED TN, NE Div., October 23, 1981).

I note the Secretary's ludicrous response to this last problem. When a complaint is made about unsigned reports, the Secretary ships the report to the doctor and requests that it be signed. These reports are often celebrating their first birthdays by then, and how these providers, who have seen 25-35 claimants per examination day in the interim, could attest to the accuracy of the report is beyond me. Disregarding the most basic concepts of fair adjudication, the Secretary doesn't request such an attestation, just a signature.

The investigative report refers to a survey by Tennessee DDS of claimants who had been referred to the Thurmans (32). The weight accorded its findings must be minimal as the person who conducted the survey admits that it did not comply with procedures mandatory at the time for conducting quality assurance reviews. See Program Operations Manual System, Part 4, Chapter VII, 7010, et seq. These procedures assure reliable results. Apparently, the sample in the Tennessee study was generated by sending questionnaires to claimants until one hundred (100) were returned. This, of course, was not a random sample. At least two systematic biases result from such a sampling: questionnaires cannot be completed by illiterates and questionnaires cannot be returned by those who are too poor to afford the return postage. These built-in biases are the most damaging to the very people who are

most vulnerable to a poorly conducted medical examination by a group like the Thurmans.

An admittedly unscientific sampling of some 250 cases handled by my office revealed that we were successful significantly less often when a Thurman report was involved than when one wasn't. The advocate—or the good administrator—must ask why. The Secretary's investigation does not answer.

Mr. Crank estimated that the Administration would spend \$137 Million on consultative examinations in FY 1981 and that consultative examiners will be used in 40% of initial entitlement cases and 75% of CDI cases. These numbers require that consultative examiners, especially volume providers, do not injure the fairness of disability adjudications. If these examinations are biased they may be so subtly, and the unsophisticated claimant may drop or lose a valid claim for want of the ability to rebut. These are the many claimants who go unrepresented, the many potential clients I do not and could not see. I worry about them.

The represented claimant will always have an advantage, but the system must operate fairly for the rest. If biased, the reports delay initial entitlements as the reports cannot effectively be rebutted before a hearing, the third level of administrative review. Unnecessary hearings are, of course, also expensive. An even greater problem is experienced by Title II recipients confronted with these reports in CDI cases: they are not entitled to any hearing before benefits are cut off. See *Mathews v. Eldridge*, 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed. 2d 18 (1976).

What can and should be done, and by whom? The testimony before this Committee indicates there are systematic problems with consultative examiners which are exacerbated and noticeable in volume providers. No one verifies that the medical assistants who take histories, a vital aspect of an examination, know what questions to ask or that people who take X-Rays know a Roentgen from a Rastafarian. Note that market incentives are not trustworthy here, as malpractice liability of these physicians, who specifically disclaim any physician-patient relationship with these claimants, is questionable, at best. No one checks to see that these lovely reports are based on reality, that the printed page reflects practice. Similar failure has caused great embarrassment lately to two of this nation's greatest newspapers. No one verifies that the fragile equipment used to perform medical tests has withstood the rigors of its medicine-show travel.

Most of these problems should be addressed by the Secretary, with uniform standards for administration of this nation-wide program. In his zeal to protect the public coffers, the Secretary has pooh-poohed concern with the quality of the system. The public fisc is only one aspect of the public weal, though, and my clients would rather spend another dollar or wait another day to get an examination they could trust. Legislation being a cumbersome tool for carving much of the needed regulation, this Committee ought to be reluctant to use it but willing to let the Secretary know it will be used if he does not assure:

1. That a certain minimum time be spent with each claimant. This should be at least 20 minutes. Tennessee presently requires that no more than 3 examinations per hour be scheduled by a volume provider.

2. That paraprofessionals be competent. Standards could be set and the provider be required to certify, under penalty of perjury, that employees of the provider meet them. An additional enforcement mechanism could be requiring treble refunds of all fees paid to providers who made false certifications. These provisions could be made part of the provider's contract. Periodic inspections could be made.

3. That medical equipment be serviceable. An enforcement scheme analogous to that in #2 could be adopted.

4. That the examining physician certify that the report is made from his personal knowledge and from the kinds of reports from others recognized in the profession as reliable, e.g., laboratory reports.

5. That consultative examiners respond to interrogatories from claimants about the conduct of examinations. It is currently difficult to get an ALJ to exercise existing discretionary authority to subpoena a consultative examiner. Cost is an important factor. Interrogatories are a reasonable compromise, as it is often necessary to clarify ambiguous reports.

6. That an order of preference be established for purchasing medical evidence, requiring first that evidence be purchased from a treating physician, second from a qualified physician practicing within fifty (50) miles of claimant's residence, and only third from another source. Travel fees must be payable in advance.

These standards promote quality, cost little, and could lower overall costs. They could also bolster the integrity of a system in which public confidence is waning.

Legislation is the appropriate vehicle to address the egregious problem in Title II CDI cases, where 75% of recipients are being subjected to possible termination of benefits without any chance to rebut questionable evidence. Some kind of pre-termination hearing is required.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SERVICE ADMINISTRATIONTO : Bob Waters, Disability Programs
Branch, Atlanta, Georgia

DATE: July 30, 1981

REFER TO:

FROM : District Manager
Nashville, Tennessee

SUBJECT: Suburban Internal Medicine Group

As you know a meeting was held Wednesday morning at Disability Determination Service (DDS) at the request of Mr. Peter Komlos-Hrobsky of the Tennessee Association of Legal Services, 1518 Parkway Towers, Nashville, TN. In attendance at this meeting were: Ms. Judy Thompson, Legal Services of Middle Tennessee; John Vail, Legal Services of Upper East Tennessee; and Norman B. Foaster, II, Legal Services of South Central Tennessee. The addresses for these individuals are shown on Attachment #1.

Mr. Komlos-Hrobsky contacted me the earlier part of last week expressing a concern and interest in the area involving the Suburban Internal Medicine Group (SIMG) situation and further indicated that he was interested in determining what if possible help Legal Services may be, possibly in the area of getting cooperation from physicians to assist in performing consultative examinations. They also were concerned about the possibilities of under-funding of DDS and insufficient staff to perform the necessary functions.

After discussing this with Mr. Komlos-Hrobsky, I discussed the situation with Mr. Herb Brown and as you know we set up a meeting which took place July 29, 1981.

In the interim period, Mr. Komlos-Hrobsky sent me a letter which identified two areas which basically summarized the areas that we discussed over the phone previously. A copy of this letter is attached as Attachment #2.

The discussion lasted approximately three hours and representatives from Legal Services are genuinely concerned in trying to provide help and assistance in addressing the problems brought about with the Court Order issued by Judge Glen W. Williams. They discussed the possibility of our looking at Health Care Centers to assist in handling some of the consultative examinations. It was pointed out that these Health Care Centers are spread throughout Eastern Tennessee. Some of them are in rural areas and that this might be a possibility

Exhibit A
11

for consideration to assist in the consultative examination area. They also offered the possibility of going to State legislators to assist in whatever way possible in addressing the problem of funds and staffing for DDS.

There were a number of areas in which they had questions in relationship to what was being done on an immediate basis as far as SIMG was concerned. After discussing various aspects of the situation, Legal Services' representatives were asked specifically what they were interested in accomplishing as far as our meeting of July 29th was concerned.

First of all they agreed that the meeting was beneficial since it provided them with an opportunity to meet and talk with myself, and more particularly, with Mr. Herb Brown. They were all in agreement they obtained additional insight into the working relationship of DDS and consulting physicians and how the procedures actually worked. They were also pleased in that they felt the lines of communication at this point were open, that we were sincere in listening to and trying to provide a means of communication for them to express their interest and concerns as it relates to this situation.

They were asked at this point what they would like to have conveyed to the Regional Office. Their first concern is the Administration seems to view the Court Order in relating just to the seven cases specifically identified. They feel the Administration should be viewing the Court Order as identifying the practices of SIMG are in question and that the Judge has found the practices, procedures and methods employed by this group of physicians as being fraudulent and that the whole process utilized by this group are in question and not just the seven cases alone.

Secondly, that immediate and expedient action be taken to provide information to all Administrative Law Judges (ALJs) as to how the cases involving SIMG medical reports are to be handled. Earlier in our discussion Legal Services' representatives indicated they were under the impression the ALJs had not received any instruction as to how to handle cases involving SIMG medical reports and they (ALJs) were not in some instances remanding these cases to DDS to get additional consultative examinations. If you will recall, I contacted you to determine just what information had been provided to the ALJs. Doug Bunker got back with me the same morning and advised that at present no information had been disseminated to the ALJs, but that Commissioner Svahn and the Acting Commissioner for Office of Hearings and Appeals and Office of Disability Policy had met to discuss the problem of SIMG and that OHA was in the process of drafting for distribution instructions that would hopefully be distributed to the ALJs by next week (8/3/81). This is what the Legal Services representatives are asking be expedited.

Third, they strongly emphasized that a thorough investigation be made into the SIMG situation and that particular care be taken in determining the qualifications and the background of individuals selected to conduct the

investigation. It should be a blue ribbon selection to insure the investigation will be fair and above question, that it will be wide ranging to cover all of their (SIMG) operations, not just in Tennessee but also in the other states, and that it be a wide open investigation, one which claimants can present testimony as to the method and examination provided to them are evaluated, that employees at the DDS, ALJ, attorneys representing clients and others, be given full opportunity to testify and present examples that would relate to the investigation.

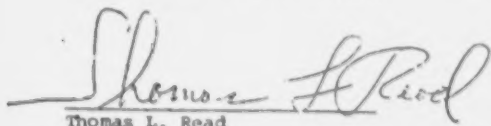
Fourth, in an effort to afford the broadest input possible, Legal Services has agreed to act as a small part of that input to the extent they would be willing to serve as a contact in the investigation and identify claimants and attorneys who would be willing to testify. In this offer it was made clear they were not trying to present a one-sided picture, but since many of the claimants they represent on a continuing and on-going basis had had examinations conducted by SIMG, they felt these individuals should be given an opportunity to comment and further that Legal Services was in a position to quickly identify these individuals.

They also requested that during the course of this investigation one contact source should be established in the form of an ombudsman, liaison, coordinator, or what have you as far as title is concerned, that they and other interested individuals could turn to to make inquiries, to provide input and to determine the progress of the investigation. In reference to progress of the investigation, they were not asking for confidential information, but only for information that would be considered reasonable to be released during such an investigation.

We discussed these various requests with the Legal Services' attorneys and it was made clear by them, and let me emphasize not as a threat, but as a means of representing their claimants to insure that justice was done in all cases, they would not be hesitant to file litigation on an individual case by case basis as the circumstances require, or to file a class action suit on any facet of the situation that was necessary or to pursue to the full degree any course of legal action open to them if a full, fair, impartial and wide ranging investigation was not conducted in this case.

It is my considered opinion these individuals are sincere in their concerns, that they can, will, and intend to pursue the situation until it is resolved in a fair and timely manner. They sight examples of horror stories concerning the performance of SIMG and I believe they fully intend to pursue it now that the door has been opened. It would seem to me that where we have the latitude and opportunity to cooperate, we should continue to work with this organization, since it would be to the best interest of the public and the Administration to do so.

If I can be of any further service in conjunction with this, please do not hesitate to let me know.



Thomas L. Read

Attachments

Exhibit A
13

Exhibit A
14

Mr. BAILEY [presiding]. Thank you both very much for your statements. Let us get into some questions. We do have other witnesses, and we are going to have to move along. Chairman Pickle, incidentally, will be back. He will review the testimony. All members of the committee will. So I do not want you to feel that it is going to go unexamined or something.

Let me ask both of you, have you had experiences with other volume providers? The experiences you have had, have they been limited to one particular volume provider? You mentioned the medical shortfall. You have the shortage of medical help there in your area, Mr. Vail, and eventual consultative exams. Have you had experience with them at all?

Mr. VAIL. We have had a lot of experience with individual consultative examiners, but the Thurmans are unique for us.

Mr. BAILEY. Are they different in quality? Has it been your experience that the volume providers are different?

Mr. VAIL. I think that you see some of the problems with the Thurmans across consultative exams. Some of the more egregious problems with the Thurmans are peculiar to very high volume providers.

Mr. DROZDOWSKI. I think also the problems with the high volume providers, as I said in my statement, are magnified by the fact that they are high volume providers, so those problems you see many more times.

Mr. VAIL. Like the thing with the assistants. That happens with individual CE's, too. We only learn about it with the Thurmans because of the volume. It becomes statistically significant. We can pull out big numbers. But subjectively, when you go back and look at it, some of those kinds of problems exist with small CE's, too.

Mr. BAILEY. So the recommendations you would have, or the approach you think should be taken, is an overview of the consultative examination procedure itself, and try to maybe approach it from a general point of view as opposed to simply volume providers? I have watched both of you sitting out there. You have heard some of the other recommendations that we have had here earlier today, in terms of physicians being required during the consultative examination to spend a certain amount of time, those types of things. How do those recommendations settle with you?

Mr. VAIL. Some of them are very good. I have recommended a minimum time myself. I wanted to clarify that, because I said at least 20 minutes. Now, I suggest that, after talking with some doctors about what you can do, and the peculiarities of buying minimal evidence. That would be a minimal figure providing the doctor already had in hand and had read the historical information about the patient.

Mr. BAILEY. So you would recommend a minimal time of some reasonable sort. Second, you feel that the consultative physician should have available—there should be a requirement that the information is available, or a file, or dossier, or whatever, of prior medical information, that at least there is some kind of complete information available to that physician.

We had Mr. Glancy, who had suggested that the information should be from the consultative examination and referred to the

original treating physician for review. What are your thoughts on that? A previous witness expressed doubt. What are your thoughts?

Mr. VAIL. I think that would be very useful. Sandy Crank admits and the law is clear, that the preferred source of evidence is the treating physician. One of the problems you run into often in litigating cases is that the treating physician is simply not familiar with the language and the standards of the SSA.

Mr. BAILEY. So you think that during the referral or treating process, some information on what to look for, in terms of disability standards, that that information should be focused also?

Mr. VAIL. I would like to address a comment that was made about that, too. It was noted that that is something that a claimant's representative could do. A whole world of claimants is not represented, and a whole lot of them, because of things like this, drop out of the system. Those are people that I do not see; I could not see even if we had all the time in the world. And I worry about them.

Mr. BAILEY. Mr. Drozdowski, you made some comments aimed, I assume, at the word-processing practices of some of the volume providers.

Mr. DROZDOWSKI. Yes.

Mr. BAILEY. You indicated that some of the commentary—and we have had testimony already about the voluminous nature of the reports—are giving the appearance that a detailed and very involved examination had been done, when in fact the claim is made that that has not been the case. You say that in many cases these word-processing responses obviously do not represent, then, a dictated or some type of analysis done by the physician in the cases.

You are telling us they indicate some type of apparently cue or input, some sort of data input that triggers a response or a word, and we end up with the same paragraphs, words, and so forth, in a multitude of cases in response to a particular thing. Is that what you are saying?

Mr. DROZDOWSKI. Yes, sir. I think in the deposition of Dr. Martin, he noted that they used kind of a checklist at the beginning of their examination, when the aide will supposedly get a history from the patient. It appears very likely that what they would then do with this checklist is have someone who is working on the word processor, unless there is a notation that something is not normal, they would just probably get out the—

Mr. BAILEY. Could you possibly check and see, just cross index to see if you have the information available to you and see if that type of response indicates that that information is being included in these reports coming from different physicians, different cases, different days, that kind of thing?

Mr. DROZDOWSKI. Yes.

Mr. BAILEY. Or did you already verify that?

Mr. DROZDOWSKI. Congressman, I think if you look at the attachments to my testimony, I attached some affidavits.

Mr. BAILEY. I have it, yes.

Mr. DROZDOWSKI. And some copies of some Thurman reports. If you read through those reports from the Thurmans and put them side by side, put the pages next to each other, you will see what I am talking about.

Mr. BAILEY. Last, on social security, your feeling is that social security—and I must tell you, I share it with you—social security has not—this may be an understatement, so bear with me—that social security has not cooperated in providing any guidance, certainly has not done much in terms of an in-depth look at this problem, even since we began looking at it.

I think what they are doing is inadvertently they are going to create a huge problem for themselves in terms of public image and respect, and somebody is going to be in trouble if they do not get off their behinds. And I hope whoever is here sitting and listening, will respond to that and start doing something about this problem, and provide a little guidance and leadership with it.

It is just becoming embarrassing to the Social Security Administration, it appears, because they could at least look into this a little closer, I think. It is a personal opinion on my part, and apparently additional Congressmen are beginning to share it.

You do not feel the criticisms you raised were adequately responded to?

Mr. VAIL. Not at all.

Mr. BAILEY. Just plainly and simply, were not responded to?

Mr. VAIL. Yes.

Mr. DROZDOWSKI. Yes.

Mr. BAILEY. Personally, I might say for your benefit that I, in my experiences, have had the same difficulty, and I think it will be looked into further. I am sure that it will be. I want to thank you.

Mr. Jacobs is here. Do you have any questions?

Mr. JACOBS. No.

Mr. BAILEY. I would like to thank both of you very much. I hope you will stay in touch with the committee and submit additional information as it becomes available to you. The staff is very hard working and helpful, and I am sure they and us would love to have it.

Thank you.

Mr. DROZDOWSKI. Thank you, Congressman.

Mr. VAIL. Thank you.

Mr. BAILEY. The next witness before the committee Dr. David D. Ketrosier, M.D., Hopkins, Minnesota. Mr. Ketrosier?

STATEMENT OF DAVID B. KETROSER, M.D., P.A., HOPKINS, MINN.

Dr. KETROSER. Thank you, Mr. Bailey and Mr. Jacobs.

First, I would like to apologize for my late arrival. The weather precluded my arrival any closer than Philadelphia.

I would also like to apologize if any of what I am about to say is redundant, but I feel the points I am about to make would even bear some repeating.

As the sole volume provider appearing at this hearing to discuss volume providers, I feel it is useful for me to give my perspective of the pertinent issues. I intend to discuss the reasons the medical community is unable or unwilling to satisfy the State agencies' needs, why volume providers can be the ideal solution to these problems, and certain rules which I would recommend for both the volume vendors and the State agencies.

The reasons for the failure of many medical communities to obviate the need for volume providers—

Mr. BAILEY. Dr. Ketrosier, let me ask one question before I go. I am running way behind schedule. Congressman Jacobs, who has seniority anyway, will take over. I want to ask you one question. Please forgive my interruption.

Do you think that the Social Security Administration should do something in the way of guidelines or recommendations to State agencies on setting standards for the benefits of those volume providers who do a good job and to the detriment of those who are obviously taking advantage of the system? Or do you think that is not the way we should go?

Dr. KETROSER. That is the reason I came here today.

Mr. BAILEY. You think the Social Security Administration should provide some guidance?

Dr. KETROSER. Yes, sir.

Mr. BAILEY. You have answered my question. Thank you very much.

Mr. JACOBS [presiding]. Please continue.

Dr. KETROSER. First of all, there is a problem of what the physicians are being asked to do. The disability offices want the patient to be scheduled soon after the request is made, often not an easy task to accomplish in a busy private practice office. In addition, the typed report, along with all laboratory results, is to be returned within 2 weeks, again not something the usual doctor's office is set up to do.

Finally, the information needed, both in format and in content, is different than most physicians are used to providing. Whereas most physician specialists consider themselves such experts that their opinions should be considered a valuable commodity, the disability determination service is asking for objective data in both the history and physical, and specifically asks that doctors refrain from opinion statements, which tend to be subjective and nonreproducible, and which would result in inconsistent determinations.

The reasons for this objective bent are logical and justifiable, but the average practicing physician neither knows of them nor cares. He is unlikely to be willing to change his thought processes for 1 hour once or twice each week.

The second problem is that in many parts of the country the distribution of physician specialists is such that there are not adequate numbers of physicians to even handle the basic needs of the community. Primarily, in the fields of neurology, orthopedic surgery, and even psychiatry, I have found that the State agencies often have entire large communities where there are no physicians available to them.

In these cases, they have no choice but to have claimants travel long distances to see an available specialist. In addition, both for psychological and financial reasons, most specialists in orthopedic surgery prefer to maximize their time spent in the operating room and minimize the time spent in their office. It is difficult to convince them to add time to their office practice to see patients on whom there is no chance of doing surgery.

Finally, the fee schedules are in some States so unrealistic that the physicians would in effect be subsidizing the State agency by

giving up a certain number of hours of being paid at community standard rates, to be paid at rates that are often only 50 percent as large. In addition, the State agency which is responsible for physician payment is usually not the same agency that is asking us to see the claimant. There is, therefore, no vested interest in seeing that we are paid in a prompt manner, and there is often a delay of from 60 to 120 days between performance of the examination and payment.

For all these reasons, it is clear that for the foreseeable future the private medical community is not going to be the answer to the needs of the State disability agencies, especially with the recent program of reevaluating people already on disability, stretching the ranks of available physicians even further. It would seem, then, that the logical solution would be to find capable physicians who are willing to do the work and who are aware of the special needs of the State agencies for producing quality objective reports which are both objective and thorough, and which can be produced in signed form within 2 weeks.

I represent one group of such physicians who have been performing examinations for the Minnesota, Indiana, and Michigan State agencies for up to 4½ years. Because we have physicians spending an entire day seeing disability claimants, scheduling procedures for the State agencies are much streamlined and examinations are available to claimants in a much more timely manner.

We know how to provide the objective data needed and our procedures are set up to provide it in the timeframe required. In addition, our internal medicine doctors are never allowed to see more than two patients per hour, and even this figure is only rarely attained.

Therefore, it would seem that, when run properly, the volume provider should be viewed as a vital link in the social security disability program's ability to function as it should and not as a group of carbetbagging opportunists preying on the defenseless disabled of our country.

I would like to recommend at this time, first, some rules for the volume providers which would attempt to insure that the claimant's rights are protected, and then some rules for the State agencies which would make them more palatable in dealings with both volume providers and private practitioners.

One. All claimants should be examined by a physician who does the entire history and physical examination. There is no question that registered nurses and technicians could do some of what the physician is doing, but there is equally little doubt that only a physician is trained to evaluate all the nuances of history and physical which come into play.

The State agencies are unable to evaluate whether additional information was available but not obtained because they have no golden standard of total information against which the nonphysician exams can be judged. In mathematical logic terms this would be called necessary but not sufficient.

Since we are talking about information which will be used to make decisions which for many are crucial to their ability to remain above the poverty level, we need to give every effort to obtain the most accurate and complete information possible. My

experience leads me to believe that there is no way a physician can do this sort of examination at a rate of greater than two patients per hour for internal medicine, neurology, or psychiatry. For orthopedic surgery, because both the history and the physical examination tend to be much more focused on a particular joint or body part, this rate can sometimes be increased to between 2 and 2½ patients per hour, but even in this specialty, often the exams will take 30 minutes to perform adequately.

Two. Physicians should evaluate patients in their area of expertise. Even if an internist can give the history and range of motion needed for an orthopedic problem, their experience is often too limited to give recommended therapeutic modalities which could resolve the problem or expected prognosis which could result in changing whether the claimant is considered disabled or not.

Three. Stress testing should be done by physicians trained in cardiology who are in the stress testing room at all times, not just in the office. There should also be a stress technician in the room and the room should be equipped with an adequately filled crash cart and defibrillator. Too often, stress testing, a commonly required test for disability examinations, is being done using a single channel recorder with only a technician in the room. Because of the inherent risk in the test, this is both poor judgment on the physician's part and an unnecessary risk for the disability claimant, who is at the State's mercy in assuming that the office he or she is being sent to will use all prudent safety precautions.

Four. X-ray testing should be done using fixed, nonmobile equipment. Truly portable equipment which can be easily carried by a technician exists, but it is technically unsatisfactory for obtaining adequate views of the spines and chests of the large patients we are often asked to see. Large equipment which has been fitted into a mobile van may have adequate power for the tasks, but the inherent unreliability of most of this equipment, which is fairly delicate, while being bounced along on our Nation's roads causes too frequent breakdowns. For claimants who often must come long distances and make special travel plans, this seems an unnecessary risk for financial savings they will not share.

Also, X-rays should be read by either a radiologist or an orthopedic surgeon. The training which internists receive in this country is usually not adequate for anything but chest X-ray readings, if that. Because the report of X-ray results which goes into a State agency often is crucial to the decisionmaking process and because there is no objective way for the State to tell whether the physician is reading the X-rays adequately, it is necessary that only those specialists who are traditionally trained to read them be allowed to do so.

Five. Finally, the examining facility itself should be examined before operations begin by the State agency and at least annually thereafter on an unannounced basis. This can be used to document the state of the office as well as the compliance with all of the other above-mentioned recommendations.

My recommendations for changes in the State agency procedures otherwise center around the problems with payments. First, there is the obvious suggestion that the fees paid by the State agency should become more closely attuned to the fees paid to the medical community. These need not be identical, but when agencies find

themselves being rejected out of hand by all but those doctors who cannot find other patients or in those communities where the physician population is so large as to make some competitive free enterprise creep into the medical community—as I am sure you will agree, the former is not the type of doctor the program seeks, and the latter situation is too rare at this time to be considered a solution.

Second, I recommend that there be a change in the payment procedures such that the disability determination services, who have a vested interest in seeing their consultants paid, be given the responsibility for issuing the check. As it presently stands, the checks are issued by the State auditors, who have no more desire to keep this highly volatile and individualistic group of professionals happy than they do paying large corporations who have contracted with them for trash removal or street repair, and who are somewhat more used to delays.

The results are often physician defections from the State panels. A nationwide payment agency would be an acceptable alternative only if it can avoid the commonplace problems found in programs such as medicare payment systems, whereby a 4-month wait for payment is not uncommon.

I hope with this discussion I have demonstrated that, rather than being considered unprincipled opportunists, it is possible for volume vendors to be skilled and competent groups who have found a need in this country for medical services and are filling it in a way that benefits the claimants, the State agencies and themselves, with no group suffering in any way from their existence.

Mr. JACOBS. Thank you very much, Doctor.

A group of our staff assistants has prepared some questions under the direction of Mr. Fred Arner, and Mr. Arner will inquire.

Mr. ARNER. You probably had not arrived when Mr. Pickle described the system used by some of the major volume providers and the ones that have come to the attention of the committee where in the East, in the mid-East that operates in some six States, works with a system where worksheets on medical examinations are put together, then examinations are given in advance. The results are sent then in terms of the worksheets and examinations to a third party in Florida, who completes the word processing part of the operation, gets some of the exams examined by physicians down there, and incorporates it into the report.

Then the report is shipped back to, say, the physician in Pennsylvania, who would now under the new system sign the report. I do not think he has the worksheets with him when he signs the report. The worksheets go to somewhere in Michigan and the report is given to the local DDS.

Does not this type of operation lend itself to omissions which may not be picked up by the physician when he rereads this report? How does this compare with your operation?

Dr. KETROSER. Well, it obviously, I would think, although I have not gone through the actual specifics of how we have done it and followed the whole things along, from your description and everything I have heard I would think that in a high percentage of the cases they probably wind up getting the appropriate information. I guess my major concern would be that percentage, and I certainly

could not guess what that percentage would be, of cases where there would be significant data missed in a situation like this.

My personal opinion is all we can do is try to set up the situation with as few misses as possible. I would think their system would have a greater number of misses than the way we do it, which would be—I hate to use the term “old-fashioned,” but basically the doctor sits down with the patient and does a history and a physical examination and dictates the report.

A certain amount of that is still going to depend on the quality of the physician, but I still think that that is going to be the way that will have the highest accumulation of information.

Mr. ARNER. I take it from your testimony you think 25 to 35 examinations in a day for a physician seems somewhat in excess. I guess we have a problem here in getting a standard in this whole area. Mr. Pickle has introduced a bill, H.R. 5700, which would establish an advisory council on medical affairs, which would look at in a sense a number of functions. We have added another one, to evaluate the process of procuring medical evidence, including the establishment of standards covering the purchase of medical examinations.

We have asked Social Security what they have done to establish standards in this area. They have said they have gone to the AMA, but the AMA suggested:

that we look into peer reviews of consultative services through such organizations as the American Society of Internal Medicine, medical foundations, and State medical associations

Does it not sound like we need to have an authoritative group with a specific mandate to promulgate some standards in this area?

Dr. KETROSER. It does. Unfortunately, it seems to me that the only group of physicians who really know what disability is looking for and how long it would take are the volume providers, or possibly the physicians who are working in the State agencies.

Mr. ARNER. You would think that some volume provider perhaps should be on this council as established?

Dr. KETROSER. I would be more than willing to. I guess the problem becomes that if you ask a group like the AMA how long it should take, what sort of procedures should be done, they are saying that they do not think they are competent. I think it is probably true, they do not have any idea what you want.

The average doctor—this is just something that happens to me from time to time with my physicians. We may see a patient who the doctor thinks has tuberculosis. The doctor will call me up and say, I think we need to do a Mantoux on this patient. I will have to explain to this doctor that, although that would be a very rational thing to do if you were taking care of the patient, from a disability point of view what is more pertinent is pulmonary function testing.

Mr. ARNER. Also in this bill we have authority to pay money out of the trust funds to reimburse med schools for setting up courses on the evaluation of medical impairment and continuing education for State consultative exams.

Dr. KETROSER. That sounds like a tremendous idea.

Mr. ARNER. As to the billing problem, also, as you said, there is a provision in there that would set up a fiscal agent, nationwide

fiscal agent, and pay fees at the 100 percent of the prevailing fee as determined locally. You have stated some reservations about a medicare mechanism slowing billing. I guess we had some indication to the contrary, that it was faster than some of the billing that went on in some of the States.

Do you have any comments on this?

Dr. KETROSER. I have experiences from four State agencies. They range all the way from state agencies having to be called every 2 to 3 months and chided and occasionally threatened in order to send checks out; other State agencies are just automatically paying within 30 days.

As I said, I think the main problem is the people who want the volume providers, who want all of their physicians to be paid, have almost no input into how quickly that is done.

Mr. ARNER. I have two more quickies here.

I take it you take a dim view of the use of mobile vans for X-ray equipment. This has been pretty big in a number of the volume provider operations.

Dr. KETROSER. It may just be my own ignorance. I would have to defer to the experience of the States who have used those people. I have inquired, and obviously if you can get a highly powered enough unit into a van and move it from place to place, it is the most economical way to do things as long as it does not break down.

Everyone I have talked to in the industry has told me that they have a great deal of difficulty doing that. I am just not willing to have 16, 30, 50 patients sent to my office and turned away.

Mr. ARNER. I take it there should be a very skilled technician operating that? There were some questions in that area.

Dr. KETROSER. I think most States—I do not know the exact number—many States have requirements that you must be a registered technician.

Mr. ARNER. I think we had a problem in Pennsylvania.

Dr. KETROSER. Some States allow people that are not registered to do it. Then you are just at the mercy of whoever is hiring them and checking their qualifications.

Mr. ARNER. A final question as to blood samples as to whether—there is some transporting of blood samples over some substantial—from down in Pennsylvania conceivably in cases down to Miami. Does this raise problems in deterioration?

Dr. KETROSER. It depends on the tests. Tests that are done on serum where the blood cells have been taken out, it generally is not pertinent. Tests such as CBC's, complete blood counts, generally after 24 hours begin to deteriorate, and you begin to lose some useful information. Sedimentation rates must be done within a few hours or they start to degenerate toward zero and the test becomes useless. Those tests needed to be done quickly. Serum tests do not.

Mr. JACOBS. Thank you, Mr. Arner.

Doctor, your volume provider business has existed, did you say, for 5 or 6 years?

Dr. KETROSER. It began in 1977.

Mr. JACOBS. 1977? Have you found it to be profitable?

Dr. KETROSER. Yes.

Mr. JACOBS. What about the inadequate fees?

Dr. KETROSER. Well, I guess just from a purely logical standpoint I would prefer that they were higher. There are some States that I think are very, very difficult for volume providers to go into. There are some States that pay \$14 for certain X-rays. The costs of getting a radiologist to read it plus the film practically equals that.

Mr. JACOBS. Your experience has not been altogether unhappy?

Dr. KETROSER. Oh, no. Basically the comment I was making about bringing up the fees was not even for the States that I am in. They are for some States that I have talked to but whose fees are so low that possibly some of the other volume vendors can go in. I do not think that I can go in.

Mr. JACOBS. Thank you for your testimony. I am sorry you had difficulty in getting here and applaud your extra effort in doing so.

The last two witnesses might as well come forward at the same time. Mr. Onerheim.

Is Ms. Walton present?

[No response.]

Mr. JACOBS. I am told by a voice that she was caught in the fog.

Is Mr. Onerheim present?

Mr. VAIL. Neither of them have arrived. We do not know quite why. We know there was one missed plane and somebody who is attempting—they both will submit—I do not know if they have submitted written testimony.

We would note especially that both of those are on volume providers about whom you have not yet heard.

Mr. JACOBS. We expect their written testimony which will be included in the record, and especially because of your comments, sir, we will welcome them.

This concludes the hearing.

[Whereupon, at 12:40 p.m., the hearing was adjourned.]

[The following was submitted for the record:]

THE COMMISSIONER OF SOCIAL SECURITY,
Baltimore, Md., February 2, 1982.

Hon. J. J. PICKLE,

Chairman, Social Security Subcommittee, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Thought you might be interested in this recent report I got on medical providers and the disability insurance program. The report outlines the results of the investigation on two of the providers of consultative exams.

Sincerely,

JOHN A. SVAHN.

Enclosure.

[Attachments]

REPORT ON THE OPERATIONS OF DRs. JOHNSON AND BYERS

The Committee on Ways and Means Subcommittee on Social Security asked the Social Security Administration to look at the activities of Drs. A. Neil Johnson and Kenneth Byers as part of our assessment of high volume providers of consultative examinations. The Subcommittee was particularly concerned because a Pittsburgh television station was doing an in-depth report on them and their connection with Dr. Richard Lipman. The investigation consisted of a number of activities. These included:

1. Visits to the DDS's in Michigan, Indiana, Pennsylvania, New York, Virginia and West Virginia to obtain in-depth information about their operations in those States and the States' activities in monitoring those operations.

2. A meeting with Drs. Johnson and Byers and their attorney, Kenneth Adams, on October 2, 1981, in their offices in Troy, Michigan to discuss their operation with

them. During this meeting, their relationship with Dr. Richard Lipman was also discussed.

3. Interviews with persons who have been examined by Johnson and Byers.

4. Review of consultative examination reports emanating from the Johnson and Byers operation.

5. Meetings with Dr. Richard Lipman to assess the relationship of his transcription service to the consultative examination reports being generated by Johnson and Byers.

Doctors Johnson and Byers started their operation in Detroit in early 1978 and expanded into five other states: Indiana (one location), Pennsylvania (six locations), West Virginia (two locations), Kansas (two locations), and New York (four locations). Their Pennsylvania offices were closed in September. Even though Pennsylvania would like to resume using their services, Johnson and Byers state that the adverse publicity generated by the series on Pittsburgh television would make it very difficult to operate effectively there. They do business in the several States using a number of names. In Michigan and Kansas they now use the name Central Medical Consultants. In New York they are United Medical Associates. In West Virginia, they operate as Bridgeport Disability Clinic.

There were at least 22 M.D.'s involved in their operation in the six States and a much larger number of ancillary personnel who may work in only one place or several. All of the doctors are either Board Certified or Board Eligible in Internal Medicine.

Where possible Johnson and Byers rent office space from local M.D.'s on a Saturday or other day of the week when the doctor does not have office hours. They prefer offices which have X-ray equipment. However, where this is not possible, they use an X-ray van leased from Dr. Lipman. In several places they have bought additional equipment; treadmills, EKG and pulmonary function testing machines.

THE JOHNSON AND BYERS EXAMINATION PROCESS

The examination process is standardized in all of their offices. It starts with the office manager's setting up a folder for each individual scheduled with whatever background medical evidence has been furnished by the DDS. A face sheet is filled out—with blocks checked for the procedures that will be completed on that individual (examination, EKG, blood studies, etc.). A series of forms is completed to record the information—pulse rate, blood pressure, height, weight, visual acuity. The requested studies (EKG, X-rays, ventilatory function tests) are obtained before the individual sees the physician. Blood is drawn for requested tests.

When the physician sees the individual, the background information submitted by the DDS, the history form completed by the medical assistant, if one was requested, and the various medical tests, if any, are reviewed. Then, the physician obtains a history considering the information on the background form. A physical examination form is completed during the course of the examination. These forms are completed by entering a number or words in the appropriate space, checking a block or circling a word. The physician may write in additional statements, if necessary.

Doppler studies and treadmill exercise tests are obtained after the examination, if requested by the DDS, and not contraindicated. A physician is said to be present during the treadmill exercise tests. X-rays are taken in the office if equipment is available, in an adjoining van containing the equipment (leased from Dr. Lipman in the Pittsburgh area), or at a nearby hospital or physician's office. Most blood work is sent to an independent laboratory in the area; that laboratory sends the results directly to Dr. Lipman's transcribing service in Miami for association with the report. Some blood is sent to Dr. Lipman but he has the test done by a local independent laboratory.

All the material generated at the examining facility is sent to Dr. Lipman in Miami. At that location, the report is typed from the physician's history and physical examination sheets using programmed word processing equipment. A formal reading of the ancillary tests (EKG, ventilatory function tests, X-rays) is performed and added to the report over the name of the physician who performed the basic examination. The EKG's and ventilatory function tests are read by a physician at Dr. Lipman's transcribing service. The X-rays are read in Miami by Dr. Allen Fishman. The blood test results are attached to the report prepared by Dr. Lipman.

The report is returned to the local office for review and signature by the physician who performed the examination. The worksheets are returned to the Troy, Michigan office for storage. The physician does not have his/her worksheet when reviewing the final report. The conclusions are already a part of the report even though the examining/reporting physician may not have seen all of the laboratory

results (particularly the blood tests and X-rays). The signing physician has the option to make changes by "whiting out" statements and writing in changes. Dr. Johnson has said that this is rarely necessary. The reports are not retyped. It should be noted that prior to mid-July 1981, when the requirement was made to have the examining physician sign the report, the reports were signed by a third party and sent directly to the DDS.

When questioned about quality controls exercised over their operation, Dr. Johnson indicated that their controls are informal. When a new office (clinic) is opened, Dr. Johnson will participate in two or three examining sessions to insure that the process is operating efficiently and that the examination forms are being completed correctly. Dr. Johnson also checks completed worksheets as they come into Troy. When new doctors are hired, they submit their curriculum vitae to Dr. Johnson who checks their qualifications.

Complaints about examinations, facilities, scheduling, etc. usually go from the claimant to the DDS where they are handled in a variety of ways depending on the nature of the complaint. State personnel found that Johnson and Byers have been responsive to problems brought to their attention. In fact, in the case of one doctor who was rude to claimants on occasion, they no longer use him to do exams.

Staff members from the Philadelphia and Chicago Field Integrity Staffs interviewed 10 disability applicants, selected at random, who had been examined by the Johnson and Byers organizations in Pennsylvania and Indiana. Three of the 10 were denied applicants and one has a hearing pending.

A majority had a positive reaction to the examinations they were given. One denied applicant felt the doctor who examined her did not give a complete enough examination. She saw him for an estimated 10 minutes. Two or three of the others felt the exam was not thorough enough. In one case the applicant complained that he thought an EKG and stress test should have been taken, and another person felt that a medical history should have been taken. (A complete exam and history may not have been requested by the DDS.)

In all but the one case of the woman who estimated that she saw the doctor for 10 minutes, the time spent with the physician varied from an estimated 15 minutes to a half-hour or more. Waiting times were short in about half the cases. The others reported waits of up to 3 hours. In every case there were tests administered by a nurse or a technician before the patient saw the physician. X-rays were administered in a mobile van, other tests in the office being used by the team.

During the course of the investigation, over 100 cases containing Johnson and Byers examination reports were reviewed by the SSA staff and by SSA's Medical Consultant Staff. While the quality ranged from very good to poor in individual cases, the reports were no less comprehensive than those received from other sources.

On the basis of the above activities, we reached a number of conclusions:

1. The Johnson and Byers operation fulfills a definite need in areas where timely, comprehensive CE's are difficult to obtain.
2. This type of operation has certain inherent problems. With forms completion, coding of forms in the transcribing operation and inclusion of the finding of the ancillary studies in Florida, omissions and misinterpretations are possible and may not be picked up on review by the consulting examiner. However, DDS personnel believe that these cases are as responsive to their needs as those done by other consultants.
3. The "second party" dealing with the vendor causes additional problems. In essence, DDS contact with and for training of the doctor performing the examination is quite limited and carried out through Dr. Johnson. This lack of a direct relationship with the examining physician impedes the DDS in monitoring performance and investigating complaints. However, when things are brought to their attention, Drs. Johnson and Byers have been very cooperative in making whatever corrections were necessary to improve their reports.
4. In our visits to DDS's, the State people indicated that acceptance by claimants of exams by Johnson and Byers and other volume sources might be improved if the claimants were given more background on the reason for an exam and the differences between this type of exam and one conducted for treatment purposes. A pamphlet has been produced by the Social Security Administration which the DDS can send to the claimant at the time a consultative examination is scheduled which explains the reason for the exam.

REPORT ON THE ACTIVITIES OF RICHARD LIPMAN, M.D.

There have been two meetings between SSA personnel and Dr. Lipman. On October 13, 1981, he came to headquarters accompanied by Kenneth Adams, his attorney (Mr. Adams is also Drs. Johnson and Byers attorney.) Social Security was represented by Herbert Blumenfeld, M.D., Chief Medical Officer; Anne Dowling, ODP; Andrew Ciulla, Director, OAPQ; Thomas Connors, OAPQ; and James Hughes, OAPQ.

The discussion centered on a description of the transcription service that he operates, his relationship with Johnson and Byers and other doctors, Internal Medical Associates and operation of the X-ray vans.

Dr. Lipman formed Internal Medical Associates which performs consultative examinations in Grand Rapids, Michigan. Dr. Lipman does not do any exams as he is not licensed in Michigan. Rather, he hires local doctors to do them. As a result of their association with Internal Medical Associates, a number of these doctors have established their own consultative examination (CE) operations and use Dr. Lipman's transcription service. Drs. Johnson and Byers are among these.

The transcription service operates as follows: History and examination forms are set up for completion by the doctor and ancillary personnel during the CE. The completed forms, X-rays, PFS's and EKG's are sent by express mail to Florida. Depending on the location of the exam, blood for lab studies may be processed locally, in New Jersey (by Met path) or sent to Florida where it is processed by National Health Labs. The results are sent to Dr. Lipman's office by Western Union. X-rays are read by Dr. Allan Fishman, a radiologist. EKG's and PFS's are read primarily by Dr. William Escoffrey, who was formerly with the Florida DDS. Dr. Lipman has backups for both of these men. Dr. Fishman bills the consulting examiner directly for any X-rays that he reads. When the worksheets are received, Dr. Lipman reviews them and codes them for the transcribers to input into the word processing equipment. The results of the tests are incorporated into the report and the lab report attached to it. The report is proofread for technical accuracy by one of the clericals and for content by Dr. Escoffrey or Dr. Lipman. The worksheets and the report are sent to the doctor who performed the exam for review and signature. In the case of Johnson and Byers, prior to September, all reports were sent to them in Troy, Michigan where they released them to the DDS. Since the implementation of the requirement that the report be signed by the doctor who actually performed the exam, they are now sent to the doctor, who reviews and signs them. He/she then sends the report to the DDS and the worksheets to Troy where they are held for a period of time.

Dr. Lipman stated that Drs. Johnson and Byers began doing exams for him in 1977. They still do some exams in Grand Rapids. When they do, they are paid on a daily basis for the work they perform. Their only other relationship with Dr. Lipman is the use of the transcription service for which he charges them on a flat rate per case basis and the rental of an X-ray van.

Dr. Lipman owns five X-ray vans, which he leases out to various doctors or groups who do CE's. They are located in Tampa, Florida; Pittsburgh, Pennsylvania; Grand Rapids, Michigan; Houston, Texas; and Massachusetts. He would like to sell them, but because of the cost the parties leasing them have been reluctant to buy. He indicated that he was involved in the design and construction of the vans.

Dr. Lipman indicated that his service does reports for a number of doctors and organizations who do CE's for Social Security. He also does some work that is not related to the program. His transcription work is tailored to the needs and wishes of the doctor/organization for whom it is being performed. Individual programs are made for each source. Included among those for whom he does transcriptions are:

1. Dr. Wallace in Georgia and North Carolina. Dr. Wallace does most of his own reports. However, when he gets backlogged, Dr. Lipman does some for him.
2. Dr. Piseck and Dr. Wind in Massachusetts—They took over Dr. Lipman's business in Massachusetts in 1977. Their X-rays, EKG's, etc. are read locally but they send the physical exam portion of the report for transcription.
3. Dr. Rabinowitz in Houston, Cedar Rapids and other locations. (Dr. Raskind works with him in Houston).
4. Dr. Diskant in Albuquerque.
5. Drs. Johnson and Byers for all of their operation except for Wichita where Dr. Henderson does reports.

On November 10, 1981, SSA representatives visited Dr. Lipman at his office in Miami, Florida, where they met with him and Attorney Adams.

Prior to the visit we had received several reports from Johnson and Byers along with the worksheets which had been completed by the examining physician and the

medical assistants. These were discussed with Dr. Lipman, pointing some of the problems that we saw in the completion of the worksheets and translation into the final report. We also saw the staff typing the reports completed by other physicians. It was very apparent that when the examining physician was thorough in completing the worksheets (writing in additional comments, rather than just checking the blocks), a better report was the result.

Another obvious key to the successful translation from a work sheet to a completed report is the programming input of Dr. Lipman.

The whole transcribing operation is well controlled and smoothly operated. It is as described by Dr. Lipman during the October 13 meeting. All personnel were knowledgeable about their jobs and went about them efficiently.

CONCLUSIONS

1. The quality of the medical reports emanating from Dr. Lipman's transcribing operation is related directly to the quality of the input by the examining physician into the worksheet. If the worksheet is well done with specific comments added by the doctor, a better, more descriptive, report results.
2. While the personnel in the transcribing operation are proficient in their part of the operation, the single key to the success of it is the programming done by Dr. Lipman on the worksheets. Without his input, we believe that the quality of the reports coming from this service would rapidly deteriorate.
3. The system which is used for processing blood for lab tests causes us concern. On occasion, two days may elapse before anything is done on a blood sample. In this time, cells could start to break down with the result that the test results could be inaccurate.
4. Any interpretations of X-rays, PFS's, EKG's, etc., done by Dr. Lipman, Dr. Fishman or others should be signed by that doctor.

Congress of the United States

House of Representatives

Washington, D.C. 20515

April 7, 1982

Honorable John Svahn
Commissioner of Social Security
HHH Building, Room 613-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Commissioner:

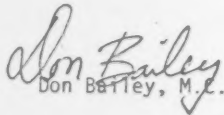
As you know, the Social Security and Oversight Subcommittees of the Ways and Means Committee have held extensive joint hearings on the Social Security Disability Insurance program, focusing particular attention on the consultative examination process and the performance of volume providers.

In February, you delivered to these Subcommittees a report on the operations of Drs. Neal Johnson and Ken Byers and the activities of Dr. Richard Lipman. In response to your investigation and to follow-up further some of our concerns, we are submitting the enclosed questions which we would appreciate your answering.

Sincerely,



J.J. Pickle, Chairman
Subcommittee on Social Security


Don Bailey, M.C.

enclosure

FOLLOW-UP QUESTIONS TO SSA INVESTIGATION OF DRs. JOHNSON AND BYERS
AND DR. RICHARD LIPMAN

- 1) When was the field work for this investigation conducted?
When did you visit the six State agencies, when did you interview the claimants examined by Drs. Johnson and Byers, and when did you complete the evaluation of Drs. Johnson and Byers medical examination reports?
- 2) Do you consider the random interviewing of 10 disability applications - six of whom were allowed benefits - sufficient to get an accurate appraisal of reaction to Johnson and Byers?
- 3) Were any efforts made to review the background information uncovered by the investigation of Mr. Bill Moushey, WPIX-Pittsburgh, particularly to review the voluminous correspondence collected by him?
- 4) How did you ascertain the validity of the reports prepared by Johnson and Byers? You state that "while the quality ranged from very good to poor in individual cases, the reports were no less comprehensive than those received from other sources." What does "comprehensive" mean and how is it a measure of quality?
- 5) You state that prior to mid-July, when the requirement that a physician sign a report was put into effect, that reports "were signed by a third party and sent directly to the DDS." Who was that third party? Do you mean that, with respect to the Pennsylvania exams, the reports were signed by Dr. Lipman in Miami and sent directly to the Pennsylvania DDS?
- 6) Under the post-July procedures the report was sent by Dr. Lipman to the examining Johnson-Byers physician and the physician's worksheet to Troy, Michigan. How could the physician accurately review the report prepared by Dr. Lipman without having access to his notes on the case? In your investigation, did you check on the accuracy of the prepared reports using the physician's worksheet?
- 7) You note in report on Johnson and Byers that this "type of operation has certain inherent problems. With forms completion, coding of forms in the transcribing operation and inclusion of the finding of the ancillary studies in Florida, omissions and misinterpretations are possible and may not be picked up on review by the consulting examiner." Then you state "DDS personnel believe that these cases are as responsive to their needs as done by other consultants." Does this answer mean that you endorse this procedure?
- 8) How large is Dr. Lipman's operation? How many cases did he process in the last fiscal year from all the states in which he has contracts with consultative exam physicians?

Follow-up questions
Page 2

- 9) Does Dr. Lipman maintain that he reviews all the physician's reports sent to him to compare their content with the reports he prepares?
- 10) What is the breakdown, in hours, of the elapsed time for processing blood for lab tests by Dr. Lipman?
- 11) What is the average number of additional comments added by the examining physician to Dr. Lipman's pre-printed worksheet? How many worksheets have two or fewer additional physician comments?
- 12) Who from SSA met with Drs. Johnson and Byers?
- 13) In your response of November 3, 1981 to questions submitted by the Subcommittee members, you stated that only 15 States had provided complete information to your teletype request of July 24, 1981. How many States to date have provided complete information to this request? How has the information collected been used?
- 14) What is Johnson and Byers' denial rate and the number of cases referred to them for the last several years?
- 15) How many of the physicians working for Johnson and Byers are board-certified? How many of the X-ray technicians are registered technicians? How many of the nurses working for Johnson and Byers are RN's or LPN's?
- 16) In your statement to the Social Security Subcommittee of March 16, 1982, you stated the actions taken by SSA to improve management of consultative examinations. One such action was issuance of Ruling 82-14 which, among other areas, provided guidelines for establishing the independence of CE physicians from other program or claimant relationships. Do you know the source of the SSDI clients of David Lipman of Miami, brother of Dr. Richard Lipman, who operates a "legal clinic" in Johnstown, PA? Are any clients the result of cases reviewed or prepared by Dr. Lipman or Drs. Johnson and Byers?
- 17) Also in your March testimony before the Subcommittee on H.R. 5700, you stated that you had taken action to provide "clear program direction" on CE report requirements. You pointed to a Security Ruling and instructions issued in the POMS. Specifically what new requirements, other than the one noted in the above question, have been laid down which were not in place when we held our first hearing on volume providers in September of last year?

Follow-up questions
Page 3

- 18) Are you aware of any regional Social Security physicians who have performed consultative examinations for State agencies? Would this be prohibited under the new guidelines?
- 19) Was any monitoring of volume providers done between the Johnson and Byers and Thurman and Thurman studies and the second-stage SSA monitoring currently underway?
- 20) Which states and which 30 CE providers are involved in the joint SSA-State second-stage monitoring currently underway?
- 21) Please send the materials developed for and used in the disability management forums held in March.



THE COMMISSIONER OF SOCIAL SECURITY
BALTIMORE, MARYLAND 21205

July 23, 1982

Honorable J. J. Pickle
Chairman, Subcommittee on
Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Pickle:

This is in further reference to your inquiry of April 7 concerning the Social Security disability program and the operations of Drs. Neal Johnson and Ken Byers as well as the activities of Dr. Richard Lipman. I regret the delay in replying.

I will answer your questions in the order presented.

- 1) When was the field work for this investigation conducted? When did you visit the six State agencies, when did you interview the claimants examined by Drs. Johnson and Byers, and when did you complete the evaluation of Drs. Johnson and Byers medical examination reports?

The field work for this investigation was conducted during the period from September through November 1981. The State Disability Determination Service (DDS) visits were as follows:

Indiana 9/17-18/81
Pennsylvania 9/24/81
Virginia 9/24-25/81
Michigan 10/1/81
New York 9/25/81
West Virginia 9/29-30/81

We interviewed Drs. Johnson and Byers on October 2, 1981. The claimants were interviewed during the period from October 1 through November 1981. The review of Drs. Johnson and Byers' reports was conducted from September through December 1981.

- 2) Do you consider the random interviewing of 10 disability applications - six of whom were allowed benefits - sufficient to get an accurate appraisal of reaction to Johnson and Byers?

We realize that this small sample of claimant reactions would not constitute a statistically reliable sample if we were conducting or designing a full study. We do feel that the results, considered

with other information we had from claimant letters and phone calls to the involved DDS's, helped to give us a feel for claimant reaction.

As part of our requirements for ongoing monitoring of consultative examination (CE) providers, we have included the evaluation of client reaction to key providers as one way of determining whether problems exist.

- 3) Were any efforts made to review the background information uncovered by the investigation of Mr. Bill Moushey, WPIX-Pittsburgh, particularly to review the voluminous correspondence collected by him?

We did follow up on the information Mr. Moushey passed on to us, directly and indirectly. We do not attempt to review background materials of reporters who are interested in Social Security issues.

- 4) How did you ascertain the validity of the reports prepared by Johnson and Byers? You state that "while the quality ranged from very good to poor in individual cases, the reports were no less comprehensive than those received from other sources." What does "comprehensive" mean and how is it a measure of quality?

Initially, 40 medical reports that could be identified quickly as being provided by Dr. Johnson and Dr. Byers were identified. Some of these reports were in case folders with other medical evidence; others were isolated photocopied medical reports. In addition, we obtained some medical reports along with the data entry sheets used by the physicians at the time of the examination.

The reports were reviewed by several physicians in the central office Medical Consultant Staff (MCS). They evaluated the adequacy of the report in describing the individual's impairment and the consistency of the reported findings against other medical evidence when available. Some of the reports were considered very good and others poor. Most of the reports were found to be acceptable in discussing the individual's complaints. In this regard, they were considered to provide as comprehensive a description of the impairment as the MCS physicians found in reviewing medical reports from a large number of sources. This was considered a measure of quality.

- 5) You state that prior to mid-July, when the requirement that a physician sign a report was put into effect, that reports "were signed by a third party and sent directly to the DDS." Who was that third party? Do you mean that, with respect to the Pennsylvania exams, the reports were signed by Dr. Lipman in Miami and sent directly to the Pennsylvania DDS?

Prior to mid-July 1981, some of the reports were signed by Dr. Johnson or Dr. Byers for the examining physician. They have stated that these "sign-offs" were done after reviewing the typed

report against the data entry sheet completed by the examining physician at the time of the examination. However, since many of the examinations were actually performed by Dr. Johnson or Dr. Byers, or a small group of physicians working directly out of their offices, most of the reports seem to have been signed by the physician who actually performed the examination. We have found no instances in which Dr. Lipman signed a report for Dr. Johnson or Dr. Byers.

- 6) Under the post-July procedures the report was sent by Dr. Lipman to the examining Johnson-Byers physician and the physician's worksheet to Troy, Michigan. How could the physician accurately review the report prepared by Dr. Lipman without having access to his notes on the case? In your investigation, did you check on the accuracy of the prepared reports using the physician's worksheet?

We were told that the examining physician would ordinarily not have a copy of the data entry sheet at the time that they signed the typed report. This was no less a drawback than instances in which the physician reviewed a report typed from dictation. We were told that Dr. Lipman reviews the typed report against the data entry sheet before releasing the typed reports. Moreover, Dr. Johnson and Dr. Byers stated that they routinely checked the copy of the typed report against the data entry sheet.

We did check several typed reports against data entry sheets and found the typed report to correctly state what was on the data entry sheet.

Drs. Johnson and Byers have now stopped using Dr. Lipman's word processing equipment in Florida and have installed their own word processing equipment with less automation. Under the new arrangement all doctors get their notes to review before they sign the completed report.

- 7) You note in report on Johnson and Byers that this "type of operation has certain inherent problems. With forms completion, coding of forms in the transcribing operation and inclusion of the finding of the ancillary studies in Florida, omissions and misinterpretations are possible and may not be picked up on review by the consulting examiner." Then you state "DDS personnel believe that these cases are as responsive to their needs as done by other consultants." Does this answer mean that you endorse this procedure?

The answer given reflects neither endorsement nor condemnation of the procedure. There are a number of constraints which prevent obtaining ideal reports, including the large volume of examinations required and the dearth of physicians willing to perform

examinations. The intent is to ensure that the examination and reports provide adequate medical evidence upon which to base a proper disability decision. We are continually looking for means to improve the examinations and reports. Recent efforts are contained in manual instructions in POMS DI 2027 and 2027.1 (copies attached). Additionally, guidance will be provided to the regional offices (RO's) and DDS's stating requirements for ongoing monitoring of CE services.

- 8) How large is Dr. Lipman's operation? How many cases did he process in the last fiscal year from all the states in which he has contracts with consultative exam physicians?

We do not know the specific size of Dr. Lipman's operation. He does not perform services directly for the Social Security Administration (SSA) or the DDS's.

- 9) Does Dr. Lipman maintain that he reviews all the physician's reports sent to him to compare their content with the reports he prepares?

Dr. Lipman has specifically stated that all reports typed in his office are reviewed against the data entry sheets by a physician. Dr. Lipman does most of the reports. Some are reviewed by Dr. Escoffrey.

- 10) What is the breakdown, in hours, of the elapsed time for processing blood for lab tests by Dr. Lipman?

Dr. Lipman states that he does not process blood for laboratory testing. We are told that most blood samples obtained by Dr. Johnson and Dr. Byers are processed in 24 hours. Blood samples obtained on Saturdays may take up to 48 hours for processing. In most of the States using Dr. Johnson and Dr. Byers, the blood samples are processed locally or nearby in the same state.

- 11) What is the average number of additional comments added by the examining physician to Dr. Lipman's pre-printed worksheet? How many worksheets have two or fewer additional physician comments?

We do not know the number of additional comments made by the examining physician on the data entry sheets. The examining physician is to write in additional comments to explain items checked on the data entry sheet when these entries are not self-explanatory and when information is obtained which is not specifically covered on the data entry sheet.

- 12) Who from SSA met with Drs. Johnson and Byers?

The SSA personnel who met with Dr. Johnson and Dr. Byers on October 1, 1981, were Herbert Blumenfeld, M.D., Chief Medical Officer, Office of Disability Programs, Thomas J. Connors, Deputy Director, Office of Adjudication Process Quality, Office of Assessment, and Donna Mukogawa, Disability Program Administrator, Chicago RO. William Edmondson, Robert Hurley, and Thomas Johnson, M.D., from the Michigan DDS, also attended the meeting.

- 13) In your response of November 3, 1981 to questions submitted by the Subcommittee members, you stated that only 15 States had provided complete information to your teletype request of July 24, 1981. How many States to date have provided complete information to this request? How has the information collected been used?

As we indicated, all States, except one, initially submitted partial replies. The information from 37 State DDS's remains incomplete. These States have advised us that supplying the additional information would be difficult for them either because their records are not kept centrally, or because tabulating the data would require additional work hours. While the information from the States is not complete in all respects, it has been sufficient for us to determine some areas where we can help the States improve their management of the CE process.

The initial monitoring by SSA of CE management processes in the DDS's has been completed. All States initially provided general descriptions of their practices for oversight of CE's. These responses were analyzed and weaknesses in handling complaints, keeping records, maintaining ongoing oversight and other areas were identified. The RO's then worked with each State to improve oversight.

- 14) What is Johnson and Byers' denial rate and the number of cases referred to them for the last several years?

By "denial rate," we assume you mean the rate at which cases containing reports by Dr. Johnson and Dr. Byers are denied by DDS's. SSA does not have information on Drs. Johnson and Byers' "denial rate" nor the number of cases referred to them for the last several years. We do not request or expect the States to maintain this type of information and they have advised us it is not available. SSA is planning to modify its quality assurance review and to do special studies to see if we can determine the effects of volume provider CE evidence.

- 15) How many of the physicians working for Johnson and Byers are board-certified? How many of the X-ray technicians are registered technicians? How many of the nurses working for Johnson and Byers are RN's or LPN's.

The information available to us in late 1981 was that 24 physicians were board certified in Internal Medicine. Some had additional training or were certified in a sub-specialty of internal medicine. The other 8 physicians who were identified as performing examinations were reported to have specialty medical training making them eligible to take the boards in Internal Medicine.

We do not know the full number of the ancillary personnel or their qualifications. The information we have indicates that several are registered nurses. Most of the others are reported to be licensed practical nurses or have worked as nurse's aides. A registered X-ray technician is also employed.

- 16) In your statement to the Social Security Subcommittee of March 16, 1982, you stated the actions taken by SSA to improve management of consultative examinations. One such action was issuance of Ruling 82-14 which, among other areas, provided guidelines for establishing the independence of CE physicians from other program or claimant relationships. Do you know the source of the SSDI clients of David Lipman of Miami, brother of Dr. Richard Lipman, who operates a "legal clinic" in Johnstown, Pennsylvania? Are any clients the result of cases reviewed or prepared by Dr. Lipman or Drs. Johnson and Byers?

We do not know the source of Social Security disability clients of attorney David Lipman, who is connected with the legal clinic in Johnstown. While the Western Pennsylvania Legal Clinic has represented a number of individuals in their claims before SSA, we know only of eight persons who received CE's by the Johnson and Byers medical firm and contacts from the Legal Clinic.

Since David Lipman's brother, Dr. Richard Lipman, prepared medical reports based on examinations conducted by the Johnson and Byers medical firm, there was a suspicion that information concerning examinations conducted by the Johnson and Byers firm had been given to Attorney Lipman through Dr. Lipman's report-writing service. However, SSA's review failed to prove that David Lipman received any information on the eight cases from either his brother's firm or from the Johnson and Byers medical firm. We apprised the U.S. attorney's office in Pittsburgh of these relationships. They declined to take any action.

- 17) Also in your March testimony before the Subcommittee on H.R. 5700, you stated that you had taken action to provide "clear program direction" on CE report requirements. You pointed to a Security Ruling and instructions issued in the POMS. Specifically what new requirements, other than the one noted in the above question, have been laid down which were not in place when we held our first hearing on volume providers in September of last year?

To respond to the concerns of the Congress, the courts, disability claimants and others about the adequacy of CE reports and the CE process in general, new and revised instructions have been prepared for POMS.

The POMS transmittal sets out the following guidelines for the first time in the permanent national instructions:

- *CE physicians' qualifications, professional conduct, reputation and relationship to the DDS, SSA, and the claimant.
- *What is expected from the CE physician in the report of examination for each specific medical speciality when a complete examination is involved.
- *The signature requirement for CE reports and the policy on rescheduling the CE with another physician when the signature of the physician who performed the original CE cannot be obtained on the report.
- *Guidelines to assist the DDS in evaluating the adequacy of the CE physicians services.

(This material is attached in response to question 7.)

Also, we have prepared POMS instructions which provide guidelines for the RO's in carrying out SSA's plan for better management and oversight of an effective CE process and a Fiscal and Administrative Letter providing additional guidelines for the DDS's.

- 18) Are you aware of any regional Social Security physicians who have performed consultative examinations for State agencies? Would this be prohibited under the new guidelines?

While we do not have records of RO physicians who may have performed CE's, the DDS guidelines have long proscribed the use of SSA or program physicians for CE's except in extenuating circumstances. The POMS guidelines have been further tightened to read:

The physician performing the CE must not be a full time or part time employee of a State DDS or any component of SSA unless there is no other qualified medical resource available. In such instances the physician cannot participate in the disability decisionmaking or review process on that claim. Also, the physician must not have any familial, financial, or other relationship to the claimant, e.g., as an actual or potential representative payee.

- 19) Was any monitoring of volume providers done between the Johnson and Byers and Thurman and Thurman studies and the second-stage SSA monitoring currently underway?

RO's and DDS's that had monitoring activities in place for volume or nonvolume providers continued that activity. Some DDS's and some RO's stepped up their activities and some initiated additional oversight. For example, one region held a 2-day orientation seminar for recently appointed DDS physicians which focused on monitoring of CE providers.

- 20) Which states and which 30 CE providers are involved in the joint SSA-State second-stage monitoring currently underway?

Massachusetts

Doctors Hospital
Boston Evening Clinic
Drs. Pictek and Wind

New Jersey

Dr. William Burke

New York

Diagnostic Health Services
Diagnostic Center

Virginia

Tidewater Health
Dr. Jo Ledwell
Dr. Martin Fritzhand

Florida

Dr. Wolfson

Georgia

Dr. Wallace

Kentucky

Dr. Martin Fritzhand

Indiana

Dr. Martin Fritzhand

Ohio

Dr. Martin Fritzhand
Allied Medical

Louisiana

Internal Medical Association

New Mexico

Dr. Barry Diskant

Texas

Centers for Health Control

Iowa

Midwest Medical Services

Kansas

Central Medical Consultants

Nebraska

Smith--Glynn Calloway Clinic

California

Health Analyst
Metropolitan Center Medical Group
Medical Assessment Group

Washington

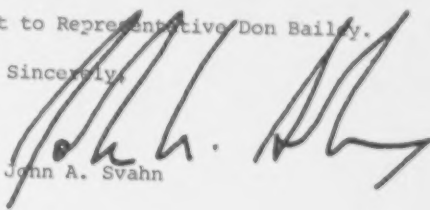
Insurance Examiners, Inc.
BBV Medical Clinic

The States in the Denver region and the State of Oregon have no volume providers but are reviewing some of their largest providers.

- 21) I am enclosing the materials used in the disability management forums held in March as requested.

Similar information has also been sent to Representative Don Bailey.

Sincerely,


John A. Svahn

Enclosures

The DDS Management Forum

Charter

On September 22, 1981, administrators of the disability determination services (DDS's) in six States—New York, Mississippi, Illinois, Arizona, Texas, and Montana—met with regional and headquarters representatives of the Social Security Administration (SSA) to establish a program to enhance management of the disability program in the States by creating a means for the exchange of operational management expertise and ideas among the DDS's. This resulting charter sets out the purpose, objectives, and limits of the program, and the roles and responsibilities of the respective parties.

I. Name

The program shall be known as The DDS Management Forum.

II. Purpose

To enhance individual DDS operational performance by the exchange of ideas and talents.

III. Objectives

The program has six main objectives:

- A. To reinforce a sense of partnership and purpose and to maintain DDS participation in the disability programs.
- B. To explore, examine, and consider new and exemplary management techniques.
- C. To promote an exchange of ideas, information, and techniques among DDS managers.
- D. To provide recognition for DDS managers.
- E. To provide an informal source of DDS managers' advice to other managers.
- F. To serve as a resource for management assistance to DDS's.

IV. Scope of ActivitiesA. Functions

Forum activities shall include at least the following:

- 1. A program of periodic management seminars, hosted by DDS's, presented for DDS management personnel and primarily by DDS management personnel.

2. A cadre of management experts serving as a source of readily available short-term assistance on specific management problems in DDS's.
3. A publications program including a periodic newsletter or bulletin, monographs on management topics, and magazine-type publications as appropriate.
4. A clearinghouse of management materials useful to DDS's and developed through the forum or by outside sources.
5. A program of peer recognition for DDS managers.

B. Limits

1. Forum activities will be concerned solely with operation of the disability determination process and not with policy issues.
2. Forum activities will not infringe upon or change existing State/Federal relationships and responsibilities.
3. SSA will facilitate forum activities but will not use the forum to present SSA program initiatives and positions.
4. Within the above limits, forum activities will be determined by DDS managers.

V. Seminar Participation

Attendance and participation in forum sponsored seminars will include:

A. DDS management and supervisory staff

1. Participation in major seminars will generally be limited to two participants per DDS.
2. Participation in special or limited subject seminars will be determined by the planning committee for that seminar.

B. Regional office management and disability program administrators

1. Participation in major seminars will generally be limited to one representative per region.
2. Participation in special or limited subject seminars will be determined by the planning committee for that seminar.

C. Central office participation will be determined by the planning committee and the Director of the Office of Disability Programs on the basis of seminar subject matter

VI. Roles and Responsibilities

A. DDS

1. Participate in the administrative activities of the forum, including a steering committee, seminar planning committee, etc.
2. Share management expertise and skills through planning, developing, presenting, and participating in seminars.
3. Serve as management consultants to other DDS's.
4. Contribute articles to the publications.
5. Contribute materials to the clearinghouse.
6. Evaluate the effectiveness of forum activities.
7. Utilize expertise and assistance offered through the program.

B. Regional Office

1. Provide a facilitator for forum activities for the region.
2. Encourage DDS participation.
3. Develop a regional resource pool of skilled SSA and DDS managers.
4. Arrange for details of DDS and regional office personnel to provide consultant services to requesting DDS's.
5. Promote interstate and interregional sharing of expertise and skills.
6. Suggest DDS managers for peer recognition through forum activities.
7. Identify successful DDS experiments and exemplary management practices.
8. Contribute articles to the periodical.
9. Participate in seminars and other activities.
10. Collect and forward DDS and other materials to the national clearinghouse.
11. Evaluate the effectiveness of forum activities.

C. Central Office

1. Facilitate seminar activities.
2. Provide coordination and support for the forum.
3. Through the RO's, conduct periodic surveys of DDS management needs.
4. With the RO's, develop a resource pool of nongovernment sources of management expertise.
5. Arrange contracting for desired services from the private sector.
6. With the RO's, develop a national resource pool of experts in the management field.
7. Develop a program of publications specifically for the forum.
8. Maintain a national clearinghouse of DDS and other management materials.
9. Evaluate the effectiveness of forum activities.

VII. Authority

Authority for the program is found in Public Law 96-265 and the implementing rules and regulations of 20 CFR Parts 404 and 416, specifically rules and regulations published in the Federal Register, Volume 46, No. 103 on Friday, May 29, 1981. On page 29190, the regulations state: "The primary purpose of these regulations is to improve the quality of State agency [DDS] performance in following our adjudicative criteria and to improve the timeliness of disability determinations." On page 29196, the management of DDS's is specifically addressed: "In drafting these regulations we had certain objectives in mind... To improve the management of the disability program both at the State and Federal levels... To preserve the basic Federal/State relationship."

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PROGRAM OPERATIONS MANUAL SYSTEM
Part 4 - Disability Insurance
Chapter 2 - Development and Evaluation

<u>New Material</u>	<u>No. of Pages</u>	<u>Discard</u>	<u>No. of Pages</u>
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Background

This transmittal introduces new and revised instructions on securing and evaluating reports of consultative examinations (CE's). The revised instructions provide guideline criteria to facilitate the CE process. The new instructions set forth specific requirements for consultative physician participation, as well as Disability Determination Services (DDS) reviewer involvement in the CE function.

Explanation of Manual Changes

DI 2027. The Consultative Examination

Subsection D has been revised to include instructions about consultative physicians' qualifications, professional conduct and reputation. The most significant aspect of these instructions addresses the issue that, although SSA does not require that the physician be a specialist in the medical field in which the CE is requested, the physician's qualifications must substantiate that he/she is licensed and, in the judgment of the DDS, has the training and experience necessary to perform the examination or test(s) required. Additionally, we have provided guidelines pertaining to the CE physician's relationship to the DDS or SSA, as well as the physician's familial, financial, or other relationship to the claimant.

Subsection E has been expanded to explain the purpose of sending background reports and available medical evidence to the physician doing the CE.

Subsection F has been revised to include more information about CE report content as well as the signature requirement formerly contained in DI E2027.

Subsection G has been revised to include five guideline elements to assist the DDS medical reviewer in the evaluation of the adequacy of the consultative medical examiner's services. The five areas of consideration are: 1) Is the CE evidence adequate for a decision? 2) Is the CE report internally consistent with the claimant's medical history? 3) Is the CE report consistent with other information, or did the report fail to mention other relevant medical

ACTION NOTES ARE ON LAST PAGE OF THIS TRANSMITTAL NOTICE

Effective Date: Upon Receipt

documentation contained in the claimant's folder? 4) Is the report adequate as to standards established in the medical profession? 5) Is the report properly signed?

Subsection H has been revised to include instructions on adjudication of cases if an unsigned or improperly signed consultative report has been received. These instructions were formerly contained in DI E2028. Instructions have been added to explain the policy on rescheduling the consultative examination with another physician when the signature of the physician who performed the original consultative examination cannot be obtained on the report because that physician is out of the country for an extended period of time, on an extended vacation, seriously ill, or deceased.

DI 2027.1. Special Considerations and Report Content of Consultative Examinations by Medical Specialty

Subsection A, Mental Disorders, now contains some of the instructions previously located in DI 2027.H., as well as revised instructions on the basic requirements for a CE pertaining to a mental disorder. This section also contains new instructions on the basic requirements for internal medicine, neurological and orthopedic CE's. The instructions outline what is expected from the CE physician in the report of examination for each specific medical specialty when a complete examination is involved.

DI 2028. Telecommunication

We have revised this section to indicate that a case which contains a fully or partially unfavorable determination and a telerecorded CE report cannot be released from the DDS until a properly signed CE report or other acceptable medical evidence is received in accordance with DI 2027.H.2.

ACTION NOTES

Table of Contents (DI 2001-2151.1.)—Add:
 "Special Considerations and Report Content
 of Consultative Examinations by Medical
 Specialty.....2027.1."

DI 2026.A.2.—In the sixth paragraph, change the fourth sentence to read: "Destroy the first copy of the SSA-883-U3 unless the regional office has issued instructions requesting that it be sent to the Disability Program Branch (DPB) in the regional office."

DI 2026.B.2.—Delete and change DI 2026.B.3. to B.2.

DEVELOPMENT AND EVALUATION

2. In title II cases, if the DO advises that the earnings requirement is not met in the AQD or later and there is no possibility of establishing an earlier onset, a consultative examination should not be purchased.
3. Be sure that all SGA issues are resolved.
4. Consider whether current severity is an issue. For cases in which it is not, e.g., closed period cases, a consultative examination should not ordinarily be obtained.
5. In title II childhood disability claims, where it is determined that an individual's alleged childhood disability did not begin before the month of attainment of age 22, development (with or without a consultative examination) to establish current disability or the precise date of onset is not necessary. The reason for this is that the individual could not be entitled to benefits as a disabled child unless found disabled on or before age 22.
6. Be alert to situations in which the claimant has an impairment that is not severe. For example, in title II or title XVI cases, a consultative examination should not be obtained where, on the basis of the claimant's allegations and an initial report of a current medical examination from a treating physician, it is apparent that the individual does not have an impairment(s) which would significantly affect the capacity to work. Additionally, a consultative examination should not be purchased where no medical report is available from the claimant's medical sources and it is obvious—based on the claimant's allegations and DO observations—that the impairment is not severe. In this instance, handle in accordance with DI 2021.F.2.b. in title II-only cases, and DI 2027.I. in concurrent title II-XVI and title XVI cases.

D. Type of Purchased Examinations and Selection of Source

1. The type of examination and/or tests purchased depends upon the specific additional evidence needed for adjudication. If a laboratory test (e.g., X-ray, urinalysis, or EKG) will furnish the additional evidence needed for adjudication, do not authorize a more comprehensive medical examination.

2. The physician selected to do the examination or test must be competent to do so. While SSA does not require that the physician be a specialist in the medical field in which the examination or test is requested, the physician's qualifications must indicate that the physician is licensed and, in the judgment of the DDS, has the training and experience to perform the type of examination or test requested. In addition, the physician's professional conduct, reputation, and dealings within the community and all government agencies must be such as to avoid an unfavorable reflection upon the government and erosion of public confidence in the administration of the program. Whenever information concerning the physician's integrity in this regard is brought to the attention of the DDS, it should resolve any doubt in favor of not utilizing that physician.

If the claimant objects to being examined by a designated physician and has good reason for the objection, the DDS should attempt to comply and schedule an

examination with another physician. A good reason might be where the CE physician had previously represented an interest adverse to the claimant. For example, the physician may have represented the claimant's employer in a worker's compensation case or may have been involved in an insurance claim or legal action adverse to the claimant.

3. The attending physician can be an especially valuable source of purchased examinations. When the attending physician is qualified to perform the additional examination or tests and generally furnishes complete and timely reports, the DDS may select the attending physician to do the purchased examination. Even if only a supplemental test is required, the attending physician is ordinarily the preferred source.

4. Independent Sources - In some situations it may be more appropriate to rely on a source other than the attending physician for a purchased examination. In the following situations, an independent source should be used:

- a. The attending physician prefers not to perform such an examination.
- b. There are material conflicts or inconsistencies in file which cannot be resolved by going back to the attending physician.
- c. The attending physician does not have the equipment to provide the specific data needed, e.g., ventilatory studies, and does not wish to make arrangements to obtain these tests.
- d. The claimant prefers a source other than the attending physician.
- e. The DDS knows from experience through purchase that the physician is not a productive source.
- f. A question is raised as to the accuracy or validity of the findings reported by the attending physician. Where the DDS knows or has reason to believe that a particular attending physician's report is not consistent with sound evidentiary and adjudicatory practices, program integrity requires the purchase of an independent consultative examination. Examples:
 - 1) Past experience raises a question as to the accuracy or validity of the physician's evidence.
 - 2) The circumstances of the examination or the relationship between the physician and the claimant cast doubt on the physician's objectivity.
 - 3) The physician's report contains signs, symptoms, and laboratory

findings which are virtually identical to those reported by the same physician for other claimants.

- 4) The report itself suggests that the claimant was feigning disability or was coached in some way.

5. All implications of possible conflicts of interest must be avoided. For example, the physician doing the examination or test must not be a full-time or part-time employee of a DDS or any component of SSA unless there is no other qualified medical resource available. In such instances, the physician cannot participate in the disability decisionmaking or review process on that claim. Also, the physician must not have any familial, financial, or other relationship to the claimant, e.g., as an actual or potential representative payee.

E. Arranging For a Consultative Examination

1. Assume that the claimant will undergo any examination that is necessary, unless the file indicates the individual is unwilling to submit to a consultative examination. See DI 2012. If the claimant is unwilling because the treating physician has told the claimant not to take the examination or test, do not persist in attempting to have it performed. Instead, contact the physician to determine whether the necessary information may be obtained from another type of examination.

2. Make copies or summaries of the disability background report and of the pertinent medical evidence available for the consulting physician prior to the examination. This permits the examining physician to be aware of the claimant's allegations, behavior as observed by others during the interview, and the degree or extent to which the allegations are consistent with the findings made on examination; thus, enabling the physician to concentrate efforts on the finding necessary to establish diagnosis, prognosis and resulting limitations. However, communications such as a DDS physician's comments should not be given to the consulting physician since they are not designed for this purpose; instead, information in these documents, which would be helpful to the consultant in performing the examination, may be extracted and made part of the DDS summary.

3. Arrange to hold the examination as close to the claimant's home as possible. While there may be some instances when an examination by a physician in a medical specialty not available in the claimant's locality is required, make every effort to avoid requesting the claimant to travel long distances to the place of the examination. If the claimant is unable to travel to the place of examination for health reasons, or if such travel might involve risk to health, arrange to have the examination at the individual's own home, institution, penitentiary, etc. If an examination at the person's residence will be inadequate for determination purposes because of the unavailability of the required special medical facilities or laboratory equipment, confer with the individual's physician as to the type of examination contemplated and whether it would be reasonably safe and feasible for the individual to travel to the place of examination.

Sometimes it may be more convenient for the claimant to be seen by a consulting physician in a neighboring State. In such situations, arrangements

can be made with the neighboring DDS to schedule the examination. Where sources in close proximity to State lines in neighboring States are being used with any frequency by out-of-State DDS's, however, arrangements for consultative examinations with those sources should be made directly with notification to the DDS in the neighboring State in each case where this is done.

F. Informing the Examining Physician—Report Content and Signature Requirements

The physicians who perform consultative examinations should have a good understanding of the Social Security disability program and the evidentiary role they play, principally because they will be requested to furnish medical evidence in support of disability claims. Further, they should be made fully aware of their responsibilities and obligations regarding confidentiality as described in DI 4095.3. Consulting examining physicians should be fully apprised, at the time the DDS first contacts them, and at subsequent appropriate intervals of the following:

1. **Report Content** - The reported results of the history, examination, pertinent requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a complete and competent examination. SSA recognizes that the detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. Thus, the extent and detail of information expected in a report of a general internal medicine examination will differ from that expected when a neurological, orthopedic, psychiatric, psychological, ophthalmological, otological or other examination is requested to address a specific issue. Moreover, the reporting of information will differ when the requested examination relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. The medical report should be complete enough to enable a reviewing physician to determine the nature, severity, duration of the impairment and residual functional capacity. The history and physical examination must be provided as a narrative of the findings and not in the form of responses to a questionnaire or a check-off list. Pertinent points in the history, such as a description of chest pain, should report the individual's statement of the symptoms, not simply the physicians' statements of conclusions. (See DI 2027.1. for details on report content requirements of specific medical specialty.)

The examining physician's report of the consultative examination should include the actual medical facts as well as a medical assessment (based on the physician's own findings) which should describe the individual's ability to do work-related activities but not an opinion as to whether the claimant is disabled under the meaning of the law since the physician may not be familiar with the requirements of the law. The examining physician should be so informed both at the time of first contact by the DDS and at any time in the future when necessary.

2. **Signature Requirement** - All consultative examination reports must be personally reviewed and signed by the physician who actually performed the examination. This attests to the fact that the physician doing the examination or testing is solely responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history,

examination and evaluation of laboratory tests results. In some instances, a medical technician or other paraprofessional will contribute to the information (e.g., X-rays or laboratory findings) contained in the consultative examination medical report. In such cases, the physician signing the report must verify the reported findings and conclusions. The examining physician's signature on a report annotated "not proofed" or "dictated but not read" is not acceptable. The physician's rubber stamp signature or the physician's signature entered by another physician, the physician's nurse, secretary or other person is not acceptable.

G. Reviewing Reports of Consultative Examinations

The DDS has an obligation to see that the money expended for a consultative examination is prudently spent and that the report is obtained as quickly as possible. In discharging this responsibility, the DDS should review the report of the consultative examination to determine whether the specific information ordered has been furnished.

The DDS should consider five elements:

1. Does the report provide evidence which serves as an adequate basis for decisionmaking in terms of the impairment it assesses?
2. Is the report internally consistent? Are all the diseases, impairments and complaints described in the history adequately assessed and reported in the physical findings? Do the conclusions correlate the findings from the history, physical examination and laboratory tests and explain all abnormalities?
3. Is the report consistent with the other information available to the DDS within the specialty of the examination requested? Did the report fail to mention an impairment or relevant complaint within that specialty that is noted on other evidence in the file (e.g., the claimant's blindness in one eye, amputations, flail limbs or claw hands, etc.)?
4. Is this an adequate report of examination as compared to standards set out in the course of a medical education? This assessment should be made by physicians based on their knowledge of writing reports. It is a somewhat subjective assessment of the character of the report.
5. Is the report properly signed? If not, see DI 2027.H.

If the report is inadequate or incomplete, contact the examining consultative physician, give an explanation of our evidentiary needs, and ask that the physician furnish the missing information or prepare a revised report.

Where the examination turns up diagnostic information or test results which would be of significance to the claimant's treatment, see DI 4064 concerning referral of consultative examination reports to attending physicians.

H. Adjudication When a Properly Signed Consultative Examination Report Has Not Been Received

The following explains what adjudicative action to take if a consultative examination report is received in the DDS unsigned or improperly signed (DI 2027.F.2.).

1. Adjudication Without a Properly Signed Report

Adjudicate and release cases involving only the following types of determinations without waiting for a properly signed consultative examination report. However, if the signature of the physician who performed the original examination cannot be obtained because that physician is deceased, reschedule the consultative examination with another physician.

- a. Open period allowance; or
- b. Continuance.

Obtain a properly signed consultative examination report postadjudicatively and forward the report for association with the file.

2. Adjudication With a Properly Signed Report

Do not release the following types of determinations until a properly signed consultative examination report (including any telephone supplement) or other acceptable medical evidence is received. If the signature of the physician who performed the original examination cannot be obtained because that physician is out of the country for an extended period of time, on an extended vacation, seriously ill, or deceased, reschedule the consultative examination with another physician.

- a. Denial; or
- b. Cessation; or
- c. Closed period allowance; or
- d. Allowance with an onset date later than alleged (title II claim) or later than the filing date (title XVI claim).

I. Purchase of Title XVI Minimal Impairment Examinations

1. There may be instances where a title XVI disability claim is forwarded to the DDS for a disability determination even though there is no history of medical treatment and the alleged impairment is apparently minimal. This situation may occur, for example, where a State or local welfare agency requires an individual to obtain a formal title XVI determination before it will authorize welfare payments. The procedures that follow may be applied in the development of such cases.

Although the method of obtaining medical evidence described below is an optional procedure to be used at the discretion of the DDS, it may be used only when:

- a. A title XVI claimant has no history of a medical examination or treatment or where there is some medical evidence of record but in the DDS' judgment it is not relevant; and

- b. The impairment appears to be minimal based on the nature of the allegations and the observations of record.

2. The absence of a medical examination and/or treatment is not, of itself, evidence of minimal impairment. An objective of this procedure, therefore, is to assure that the claimant is given an opportunity to submit medical evidence at no personal expense. (Any doubt as to whether the impairment is minimal should be resolved in favor of doing the usual development.) Alternatively, the DDS may contact the claimant for supplemental information before proceeding with the development.

3. Essentially, the DDS should ask the claimant to have a medical examination (at the government's expense) and to have the report of the examination sent to the DDS. The examination ordinarily will be of the general medical type.

a. The SSI claimant should be advised that (1) an examination is necessary in order to evaluate the current condition; (2) the DDS must receive evidence of this examination; and (3) the DDS will pay the costs involved. The DDS will not ordinarily make an appointment for this examination. Rather, the DDS will ask the claimant to make arrangements for a medical examination. If the DDS can furnish the names of physicians near the claimant's residence who can be expected to give a relatively prompt appointment, it should do so. Should the claimant request assistance in making the appointment, the DDS should make the necessary arrangements. Additionally, if the claimant appears to be unable to prosecute the claim, the usual guides for assistance to the claimant should be followed.

b. Along with the letter to the claimant, enclose a medical report form, an authorization form SSA-827, and a letter to the physician. The letter to the physician will explain the reason for the examination and provide the claimant's allegations as to complaints and symptoms. (The alleged impairment should not be specified as that may tend to direct the examination at a specific impairment.) The letter will also point out that the report should contain adequate medical history and a physical examination to permit an independent determination by SSA concerning the nature, severity, and duration of the impairment. It may also be necessary to preauthorize certain minimal laboratory testing such as hematocrit, white blood cell and differential, and urinalysis. The physician should be advised to request, by telephone, DDS authorization for additional laboratory tests deemed necessary. Finally, the letter should state the approximate fee under the State schedule. It is anticipated that if, as determined by the DDS, only a minimal impairment is involved, the report of such an examination will provide the evidence needed to make a determination.

c. DDS Action After Evidence is Requested—The claimant will be presumed able to obtain the necessary examination unless there is evidence to the contrary. Should the DDS not receive a report within a reasonable time, and there is no indication that the claimant did not receive the request for evidence, the case should be adjudicated on the basis of the evidence in file. A claim may be denied at any point if the claimant is obviously uncooperative and there is no indication that he/she is unable, rather than unwilling, to provide the requested information.

2027.1. Special Considerations and Report Content of Consultative Examinations by Medical Specialty

The following sets out what is expected from the consultative examination physician in the report of examination for specific medical specialties when a complete examination is involved. It is recognized, however, that every element listed will not be needed in every case. The facts in a particular case and the information and findings already reported in the medical and other evidence of record will dictate the extent of detail needed in the consultative examination report for that case.

A. Mental Disorders

1. The scheduling of an examination for a noninstitutionalized mentally or emotionally ill individual may require more than the usual amount of care. Experience indicates that many individuals suffering from mental or emotional disorders have never been examined or treated for these disorders and they may be emotionally unprepared for such an examination. In addition, the very nature of the individual's illness may make it difficult for the claimant to understand the purpose of the examination or to pursue the claim adequately.

2. In arranging for a psychiatric or psychological examination, review the case to determine the most desirable course to be followed to minimize difficulties in developing the claim. One or more of the following actions should be considered: (a) advise the claimant of the type of examination to be held; (b) arrange for such examination by having the DO make a personal contact, particularly if the individual fails to reply to correspondence advising him/her of the need for the examination; (c) rather than contacting the claimant it may be necessary to personally contact close relatives, interested friends, or the individual's attending physician (see DI 4021.C.2.); (d) advise the individual that participation and cooperation during the examination are essential.

3. Make copies or summaries of the background report and of the pertinent medical evidence available to the consulting psychiatrist or psychologist prior to the examination. This permits the psychiatrist or psychologist to be aware of the claimant's allegations, behavior as observed by others, and the degree, if any, of organic involvement, thus enabling the psychiatrist or psychologist to concentrate efforts on the findings necessary to establish diagnosis, prognosis and resulting limitations.

4. The report of the psychiatric or psychological examination should show the effect of the emotional or mental disorder on the claimant's ability to function at the usual and customary level of adjustment—personal, social and occupational. The report should include:

a. General Observations:

- 1) How the claimant came to the examination (alone or accompanied; distance and mode of transportation; if by automobile, who drove).
- 2) General appearance: Dress, grooming, appearance of invalidism.
- 3) Attitude and degree of cooperation.
- 4) Posture and gait.
- 5) Involuntary movements.

b. History: The psychiatrist or psychologist should indicate from whom the history was obtained and should provide an estimate of the reliability of the history.

- 1) Present illness: (The history must provide a detailed longitudinal description of the pertinent past history of the disease state in addition to the detailed description of the individual's statement of the current complaint.)

- a) Date of onset, including when the claimant became unable to work and whether an attempt was made to resume work.

- b) Claimant's complaints and how the impairment limits daily activities.

- c) Claimant's daily activities, interests, and habits (specify informant).

- d) Hospitalizations—if for treatment of mental disorders, state where, dates of hospitalizations and duration, condition on admission, therapy, condition on discharge.

- e) Therapy—type of therapy and response. If medications have been used state drugs by name and dose if known, results achieved.

- 2) History of other pertinent medical events.

- 3) Personal and family history: Include a longitudinal biographical profile of the claimant's relevant educational, social, military, marital, and occupational adjustments in terms of ability to conform to social standards, to hold employment and advance in career, and to adjust to superiors and fellow workers.

c. Mental Status—Detailed description of:

- 1) Claimant's attitude and behavior.

- 2) Stream of conversation and psychomotor activity. (Provide examples.)

- 3) Mood, affective status, and emotional reactions.

- 4) Content of special preoccupations (provide verbatim samples).

- 5) Sensorium (orientation), memory, and intellectual resources (provide examples).

d. Required Additional Information by Type of Disorder:

- 1) Psychotic reactions (both organic and functional):
In addition to a detailed description of clinical observations and findings, the report should reflect:

- a) Social, personal, and occupational regression as evidenced by restriction of daily activities, constriction of interests, and impaired ability to relate to other people.
 - b) Whether the psychotic reaction is expected to be of a longer (duration 12 months or longer) or shorter (less than 12 months duration) nature.
 - c) Frequency and duration of individual episodes and quality and duration of any intervening periods of remission.
 - d) In hospital and outpatient treatment and response (if not previously described).
- 2) Functional nonpsychotic disorders (psychophysiologic, neurotic, and personality disorders; addictive dependence on alcohol or drugs):
- a) Social, personal, and occupational limitation as evidenced by restriction of daily activities, constriction of interests, deterioration in personal habits, and impaired ability to relate to other people.
 - b) Description of manifestations of tension, anxiety, depression, hysterical reactions, obsessive-compulsive patterns, psychophysiologic disturbances, or substance use disorders.
 - c) Evidence of trophic changes resulting from chronic disuse of muscle groups, e.g., as in conversion reactions.
- 3) Organic brain syndromes:

The documentation of intellectual deterioration requires the clinical description of affect, intellect, judgment, orientation, and memory.

e. Mental Retardation:

- 1) Required psychometric documentation:
- a) Current documentation of IQ by a standardized, well-recognized measure. Acceptable instruments will have a representative normative sample, a mean of approximately 100 and standard deviation of approximately 15 in the general population, and cover a broad range of cognitive and perceptual-motor functions (e.g., the Wechsler scales).
 - b) Individual subtest scores, where appropriate, along with numerical IQ and interpretations.
- 2) Assessment of the validity of the obtained IQ as well as a description of the claimant's attitude and degree of cooperation during evaluation; also, any circumstances that might have affected

test findings (e.g., visual and physical impairments; recent prior exposure to the test).

- 3) Degree of claimant's current and predicted self-sufficiency in terms of personal, social, and occupations competence.

f. Diagnosis:

Current APA standard nomenclature.

g. Prognosis:

Probable duration and expected results of any recommended treatment.

- h. The examining psychiatrist's or psychologist's opinion of the claimant's ability to manage own benefits.

- i. The psychiatrist or psychologist signing the report must review the reported findings which must represent the information obtained in the examination of the individual. The conclusions provided by this psychiatrist or psychologist must correlate the findings. All abnormalities should be explained, or commented upon if a definitive explanation cannot be provided. This psychiatrist or psychologist must sign the report.

3. Failure to submit to a psychiatric examination will not, by itself, be sufficient reason for an unfavorable determination unless and until all other avenues of development have been exhausted. Contact a claimant who refuses to submit to a psychiatric examination, or the individual acting on the claimant's behalf, to ascertain the reason for such refusal. Explain to the individual that the examination is for evaluation purposes only and that no treatment will be given or required. If the claimant still does not understand the purpose of the examination or refuses to undergo the examination because of fear, and such fears cannot be relieved, record the claimant's reasons for not undergoing the examination and undertake other development as described below.

The additional evidence needed for evaluation may be obtained through an examination at the claimant's home by an independent physician or psychologist (this could be a physician other than a psychiatrist when one is not available), a home visit by a member of the DDS staff or a psychiatric social worker, or in the form of observation by the attending physician if the physician has personal and current knowledge of the claimant's illness. If the individual has been under care of an institution or agency with such facilities, a social service summary may be available. In those few cases where such an approach is not practical, e.g., it is physically impossible or is dangerous to get the claimant to a doctor, undertake development with nonmedical sources after discussion and obtaining permission for such contacts with a member of the claimant's family or the individual's representative. This approach should also be followed before visiting the claimant at home since it is much more productive to observe the claimant during an interview, rather than in the haphazard circumstances surrounding an unannounced visit. In the course of the discussion, explain the purpose of, and the necessity for, the proposed contact. Record on a Report of

Contact the discussion, the results of the discussion and, where applicable, the reason(s) for refusing to allow the contact. Should the claimant's family or the claimant's representative object to the contact, their wishes should be respected and the case processed in accordance with DI 2012. If, on the other hand, their permission is obtained, statements may be obtained from persons who know the claimant's past behavior and relations with others in various surroundings. Factual details as to adjustment, work record, daily activities, participation in community or group activities, or problems and difficulties (specific instances of unusual behavior, etc.) should be recorded. While the claimant's family should usually be able to provide sufficient detailed information, additional statements from disinterested persons such as neighbors, friends, former employers, supervisors, coworkers, clergymen and public officials may be needed. Although it is preferable that a member of the DDS staff accomplish this development, the resources of the district office may be enlisted. (See DI 4021.C.2.)

B. Internal Medicine (General)

1. For reporting of a general internal medical examination, the following is expected:

- a. The detail and format for reporting the results of the history, physical examination, laboratory findings, and discussion of conclusions should follow the standard reporting principles for a complete and competent internal medical examination.
- b. The major or chief complaint(s) alleged as the reason for not working should be stated.
- c. Each of these major or chief complaints should be discussed in detail under the "History of Present Illness." The discussion of these complaints must present a detailed longitudinal description of the pertinent past history of the disease state in addition to the detailed description of the individual's statement of the current complaint. It is important to present, in as great a detail as can be obtained from the individual, significant occurrences, including changes in the status of that complaint over time, hospitalizations with dates and names of hospitals, findings and treatment during the hospitalization as understood by the individual, and ongoing treatment. It is particularly important to provide a detailed description of the individual's current complaints, explaining those factors which increase the problem or impairment and those which may provide relief and how the individual describes how the impairment limits the ability to function. Pertinent descriptive statements by the claimant, such as a description of chest pain, should be recorded in the claimant's own words, to the extent possible. The information must be presented as a narrative description and not as the completion of a "questionnaire" or "check-off" form. Current medication should be listed by name of drug and dose.
- d. The "Past History" should describe other prior illnesses, injuries, operations, or hospitalizations and give the dates of these events.

- e. The "Review of Systems" should describe other complaints and symptoms the individual has experienced in the past relative to the specific organ systems as elicited in the system review. There should be a discussion of the pertinent negative findings which would be considered in making a differential diagnosis of the current illness or in evaluating the severity of the impairment.
- f. Pertinent findings under "Social" (e.g., use of tobacco products, alcohol, nonprescribed drugs) and "Family" history should be presented.
- g. The physician should indicate from whom the history was obtained and should provide an estimate of the reliability of the history.
- h. The vital signs should include the blood pressure, pulse rate, respiratory rate, and height and weight without shoes. The physical examination must provide a description of the individual's general appearance and pertinent actions during the examination (e.g., for an individual with a complaint of back or other musculoskeletal disease, how the person stood or walked, got up from a chair and got on and off the examination table). This description must be presented as a narrative and not by annotation of a "check-off" form. Those aspects of the examination dealing with the individual's major and minor complaints should be presented in particular detail, describing pertinent negative findings as well as the positive findings. Pelvic examinations should not be performed unless specifically authorized by the DDS. Specific range of motion of a joint should be reported in degrees. This should be done for joints in which there is found a significant limitation of motion. If a joint is found to have no abnormality of range of motion on gross examination, that fact should be stated rather than reporting the degrees of motion.
- i. The actual reported values for laboratory tests must be given. The laboratory should provide the normal range of values for that laboratory for the tests which have been performed. This may be in the attached laboratory report instead of being in the body of the medical report. Electrocardiographic tracings and spirographic tracings must be provided when these tests have been performed. When ventilatory function tests have been performed, the reported findings must meet the requirements of section 3.00D of the Listing of Impairments. (See DI 9500.) The interpretation of laboratory tests, such as electrocardiographic tracings, ventilatory function tests, and X-rays, must take into account and be correlated with the history and physical examination findings. If the formal reading or interpretation of the laboratory tests, electrocardiograms, X-rays ventilatory function tests, etc., has been provided by a physician other than the physician signing the report, identification of the physician providing the formal interpretation must be stated. If the interpretation is provided on a separate report sheet, that sheet should state the interpreting physician's name and address. The selection of joints to be X-rayed as representative of most involved by disease is best determined on the basis of the results of the physician's examination.

1. The physician obtaining the history and performing the physical examination must provide diagnostic and prognostic conclusions based on the clinical and laboratory findings.
2. The physician signing the report must review the reported history and physical examination findings which must represent the information obtained by this physician in the examination of the individual. The conclusions provided by this physician must correlate with the findings from the history and physical examination, and laboratory tests obtained in conjunction with this examination. All abnormalities should be explained, or commented upon if a definitive explanation cannot be provided. This physician must also sign the report.
3. The physician or medical group must be immediately responsive to complaints and requests for clarification. If not responsive, it may be necessary to seek other sources.

C. Rheumatology

In addition to the requirements for a general internal medical examination, the following specific information should be stated in reports of examination in which the primary complaint is a rheumatological disorder. Of great importance in the evaluation of claimants who allege joint or back problems as a reason for inability to work are the general observations by a competent observer with regard to stance, gait, ability to dress and undress, climb upon the examining table, grasp or shake hands, write, etc. Therefore, general observations in the physical examination should relate to these common, everyday functions which may be observed in the examining physician's office. Joint examination should include specific, detailed notations with respect to the presence or absence of effusion, periarticular swelling, tenderness, heat, redness, thickening of the joints, and specific range of motion of the joints and back in degrees. The technique for measuring range of motion of joints and spine should be in accordance with the listing requirements in section 1.00 of the Listing of Impairments. (See DI 9500.) If the range of motion is found to be restricted in any joint or spine, annotation should be made with regard to the probable cause of the restriction, whether primarily due to pain and/or influenced by observable abnormality. Joint and spine X-rays should be performed in accordance with the results of a thorough musculoskeletal examination on which basis selection of the appropriate X-rays would be made.

D. Respiratory

In addition to the requirements for a general internal medical examination, the following specific information should be stated in reports of examination in which the primary complaint is a respiratory disorder. Whether special tests are needed to evaluate the results of possible pulmonary function impairment depends on the results of a thorough history and physical examination with particular reference to the cardiorespiratory systems on which basis a probable diagnosis of chronic respiratory disease may be made. Dyspnea should be described with respect to dates and mode of onset, seasonal influence, influence of infection and precipitating activities, whether it is associated with palpitations, wheezing, chest pain, or hyperventilation symptoms. Respiratory dyspnea should be differentiated from cardiac dyspnea. Particular inquiry

should be made as to whether the claimant has a history of heart disease, has experienced paroxysmal nocturnal dyspnea or orthopnea, and whether there has been associated peripheral edema, hypertension, past myocardial infarction, angina, rheumatic heart disease, cardiac murmur, etc. Evaluation of episodic disorders, e.g., asthma, requires details with regard to onset, frequency, duration of attacks, and mode of treatment. The employment history may be important in the evaluation of pneumoconiosis or exposure to physical irritants producing respiratory symptoms. The general physical examination should particularly note the occurrence of cough, labored breathing, use of accessory muscles of respiration, audible wheezing, pallor, cyanosis, hoarseness, clubbing of fingers, or the presence of chest wall deformity. The diameter of the chest on inspiration and expiration should be noted. Distention of neck veins and ankle edema should be described if present. A specific annotation should be made as to whether the expiratory phase of respiration is prolonged. The breath sounds should be described. Diaphragmatic motion should be noted. The presence or absence of adventitious sounds on auscultation of the chest should be noted and described. Generally, a chest X-ray, hematocrit, and ECG provide useful additional information to lead one to a diagnostic conclusion. Ventilatory function studies should be performed only if a chronic respiratory disorder affecting ventilatory function is suspected on the basis of the clinical data and ancillary information. If spirometry is performed, it should be done in accordance with the specifications in the Listings for evaluation of pulmonary insufficiency.

E. Cardiovascular

In addition to the requirements for a general internal medical examination, the following specific information should be stated in reports of examination in which the primary complaint is a cardiovascular disorder. Of particular importance in evaluation of ischemic heart disease is the history with respect to chest pain. Chest pain, if present, should be described in the claimant's own words with respect to mode of onset, character, location, radiation, frequency, duration, precipitating factors, and mode of relief. A longitudinal record of the character of the chest pain should be provided by the claimant to ascertain whether there is a predictable stable pattern of occurrence and whether there is evidence of a recent change in the pattern of the symptoms. It should be noted whether the pain also occurs at rest or awakens the individual from sleep or, in addition, whether it is related to ingestion of food or movement of the upper extremities. Specific drugs used by the claimant currently and in the recent past for treatment of the cardiac disorder should be named, indicating the dosage and the response of the claimant's symptoms to these drugs. A statement should be made as to the usual duration of the symptoms, particularly of chest pain, and the time required to obtain relief on rest or after taking specific drugs such as nitroglycerin. The examination findings must provide a detailed description of the examination of the heart, including comment on the heart sounds and rhythm, and must describe any jugular vein distention (including angle of reclining at which distention occurs), abnormal adventitious lung sounds, hepatomegaly, or peripheral edema of the extremities. Where the primary issue is congestive heart failure, the history of heart disease must include discussion of the known factors in the development of the cardiac condition (e.g., myocardial infarction, rheumatic heart disease, valve replacement, hypertension) and pertinent symptoms such as dyspnea, including level of exertion at which dyspnea occurs, orthopnea, paroxysmal nocturnal dyspnea, and peripheral edema. Participation in a cardiac

rehabilitation program should be noted. The impact of the chest pain, dyspnea or other cardiac symptoms on daily activities should be specifically described. Ancillary laboratory tests, e.g., ECG's at rest and/or exercise, should be reported in accordance with the Listing requirements. The reported X-ray findings should provide a basis for evaluating any abnormalities against the requirements stated in Listing 4.02.

F. Neurological

1. Whenever possible, these examinations should be performed by physicians with specialty training and competence in evaluating neurological disorders. Although neurological examinations, as with other examinations, should not be purchased unless other sources of medical information are not productive, this is particularly true in cases of alleged epilepsy. It is important to obtain medical evidence describing the alleged epilepsy from a physician who is treating the individual for that disorder. Moreover, medical evidence of record, rather than the results of a purchased examination, is necessary to evaluate neurological disorders when the longitudinal findings are particularly critical to the assessment of the severity and duration of the impairment.

2. When prior information indicates possible incompetence on the part of the claimant, arrangements should be made to have some knowledgeable individual accompany the claimant to the purchased examination. The physician should indicate from whom the history was obtained and should provide an estimate of the reliability of the history.

3. Specific requirements of the neurological examination are:

- a. The major or chief complaint(s) alleged as the reason for not working should be stated.
- b. Each of these major or chief complaints should be discussed in detail under the "History of Present Illness." The discussion of these complaints must present a detailed longitudinal description of the pertinent past history of the disease state in addition to the detailed description of the individual's statement of current complaint. The mental or physical functional restrictions should be described with citations of specific examples. Current and past therapy for the disorder alleged should be reported and any abuse of drugs or alcohol should be discussed.
- c. The past history should discuss significant illness, injuries, or operations, particularly those involving the nervous system.
- d. The family history should provide information on pertinent positive abnormalities, particularly those involving hereditary familial conditions.
- e. The physical examination should provide a statement concerning the claimant's general appearance, nutrition, body habitus, head size and shape, and any skeletal or other abnormalities such as pigmentary or texture changes of the skin or changes in hair distribution. "Handedness" should be reported in addition to blood pressure, pulse rate, respiratory rate, height, and weight.

- f. A mental status examination should always be reported, but should be more extensive when mental capacity is in question. The physician should provide examples of responses in testing orientation, memory, calculation, insight, general understanding, and fund of knowledge. Mood and behavior during the examination should be noted, and any significant abnormalities should be described.
- g. Any impairment of speech should be described in detail with a statement as to how much ability the claimant retains and how the physician determined this. Aphasia, dysarthria, stuttering, and involuntary vocalizations must be noted and comments made as to whether speech is intelligible and fluent.
- h. The gait and station must be described in detail and examples provided as to the claimant's ability to tandem walk, walk on heels and toes, hop, dress and undress, get up from a chair, get on the examining table, and generally cooperate during the examination.
- i. Some notation should be made of the function of the 12 cranial nerves (if the first cranial nerve is not tested, as is frequently the case, this should be noted). Ocular motility and pupillary size and activity should be described, even when normal. The visual acuity and visual fields by gross confrontation should be estimated, and the basis for the estimate must be stated. Examination of the lower cranial nerves should be described in particular detail when dysphasia or dysarthria is a prominent complaint.
- j. Motor function should be quantitated, and the method of quantitation reported. For example, if a numbering system is used, the report must state which number represents normal strength and which represents total paralysis. The report must also describe to what degree motor function is inhibited by spasticity, rigidity, involuntary movements, or tremor. Muscle bulk should be described, and when there is asymmetry, measurements should be reported. Atrophy, fasciculations, myotonia, and myoclonus should be noted when present. The degree of fatigability following rapid, repetitive movements should be noted.
- k. All modalities of sensation, including cortical, should be tested. The method of testing should be recorded. When sensory deficit or pain are described in a specific distribution, care should be taken to ascertain that the findings are consistent with neuroanatomical fact. Suspected nonphysiological observations should be noted.
- l. Coordination should be tested and the ability to perform fine and dexterous movements of the hands should especially be described. Any incoordination or tremor resulting at rest or during specific tests should be described in detail and quantitated. Examples should be given describing the functional loss which occurs because of these events.
- m. Deep tendon reflexes should be described as to intensity and symmetry. Superficial reflexes should be described when present and noted when absent. Any pathological reflexes must be described in detail.

- n. The physician signing the report must review the reported history and physical examination findings which must represent the information obtained by this physician in the examination of the individual. The conclusions provided by this physician must correlate with the findings from the history and physical examination, and laboratory tests obtained in conjunction with this examination. All abnormalities should be explained, or commented upon if a definitive explanation cannot be provided. This physician must also sign the report.

G. Orthopedic

1. Whenever possible, these examinations should be performed by physicians with specialty training and competence in evaluating orthopedic disorders. It should be recognized that the results of a purchased examination in these cases will usually document only the immediate findings. Evaluation of back impairments requires a detailed description of the history, physical examination findings, pertinent laboratory findings, treatment, and response to treatment over a period of time in order to establish a 12-month duration of disabling impairment. This longitudinal information can be obtained only from a record of continuing treatment.

2. The physician should indicate from whom the history was obtained and should provide an estimate of the reliability of the history.

3. Specific requirements for reporting the orthopedic examination of the back (including the lumbar and cervical spine) are:

- a. The major or chief complaint(s) alleged as the reason for not working should be stated.
- b. Each major or chief complaint should be discussed in detail under the "History of Present Illness." The discussion of the complaints must present a detailed longitudinal description of the pertinent past history of the disease state in addition to the detailed description of the claimant's statement of current complaint. Current and pertinent past therapy for this disorder, and response to therapy, should be reported. Hospitalizations, surgical operations, and significant investigative procedures (e.g., myelography, CAT scan) should be reported giving the dates of the hospitalization and result of the procedure in as much detail as the claimant can provide.
- c. Of particular importance in reporting the history is a detailed description of the symptoms alleged, including a description of the character, location, and radiation of pain; mechanical factors which incite and relieve the pain; prescribed treatment, including name, dose, and frequency of any analgesics which are used; and a description of the claimant's typical daily activities. Any symptoms of weakness, other motor loss, or any sensory abnormalities must be described in detail.
- d. The abuse of drugs or alcohol should be discussed.

- e. The past history should discuss other significant past illnesses, injuries, or operations, particularly those involving the musculoskeletal system.
- f. The physical examination should provide a statement concerning the claimant's general appearance and nutrition, any apparent skeletal or other musculoskeletal abnormalities, in addition to the blood pressure, pulse rate, height, and weight.
- g. The gait and station must be described in detail and examples provided of the claimant's ability to tandem walk, walk on heels and toes, hop, bend, squat, arise from a squatting position, dress and undress, get up from a chair, get on the examining table, and generally cooperate during the examination.
- h. There must be a detailed description of the orthopedic and neurological examination findings. These should include a description of limitation of movement of the spine given quantitatively in degrees from the vertical position, motor and sensory abnormalities, and deep tendon reflexes. Motor function should be quantitated and the method of quantitation reported. For example, if a numbering system is used, the report must state which number represents normal strength and which represents total paralysis. The report should also describe to what degree motor function is inhibited by spasticity, rigidity, or pain. When sensory deficit or pain is reported, the specific distribution of these findings must be described. Deep tendon reflexes should be described as to intensity and symmetry.
- i. Muscle bulk should be described, and when there is asymmetry, specific measurements must be reported. Atrophy must be reported in terms of circumferential measurements of both thighs and lower legs (or upper or lower arms) at a stated point above and below the knee or elbow given in inches or centimeters. A specific description of atrophy of hand muscles may be given without measurements of atrophy, but should include measurements of grip strength.
- j. The physical examination findings must be determined on the basis of the physician's observations during the examination and not simply a report of the claimant's allegations, e.g., the claimant says the left leg is weak, numb, etc. Alternative testing methods should be used to verify the objectivity of the abnormal findings, when possible, e.g., a seated straight-leg raising test in addition to a supine straight-leg raising test.
- k. When X-rays or other specific laboratory tests have been performed, the physician providing the formal interpretation must be identified. If the interpretation is provided on a separate report form, that report should be attached.
- l. The physician signing the report must review the reported history and physical examination findings which must represent the information obtained by this physician in the examination of the individual. The

conclusions provided by this physician must correlate with the findings from the history and physical examination, and laboratory tests obtained in conjunction with this examination. All abnormalities should be explained, or commented upon if a definitive explanation cannot be provided. This physician must also sign the report.

2026. Telecommunication

Unless indicated otherwise, the telephone may be used to develop medical evidence (including capability statements) in all cases; initial, reconsideration and continuing disability—particularly as a means of expediting development. Where necessary to obtain supporting clinical information or data on which the telephonic report is based (e.g., spirometric tracings are required per Listing 3.00), the source should be asked to mail such information.

Where medical evidence is obtained over the telephone, the telephonic report must be sent to the source for a signature in every instance. When medical evidence and a capability statement are to be obtained from the same source, both should be included in the statement sent for signature to avoid sending multiple requests.

A case which contains a fully or partially unfavorable determination and a telerecorded consultative examination report cannot be released from the DDS until a properly signed consultative examination report or other acceptable medical evidence is received. (See DI 2027.H.2.) Otherwise, e.g., in favorable determinations involving telephonic consultative examination reports or cases involving telephonic medical evidence of record only, adjudication should not be delayed pending receipt of a signed report but, instead, should proceed based on the telephonic response and other evidence of record. When, however, other evidence does not lend itself to a telephonic report, such as when spirometric tracings are requested, adjudication should not proceed until after this evidence has been received and reviewed. (Exception: A presumed disability or blind determination should always be considered in title XVI claims.)

Immediately upon transcription of a telerecorded report or telephone contact, the DDS will review the transcript and any other evidence in file to determine if sufficient medical evidence has been obtained to make a disability determination pending receipt of signature. If sufficient medical evidence has been obtained and a signature is not needed prior to adjudication, the determination should be made and processed in the regular manner, and the transcript sent to the medical source for review, signature and return. Where sufficient evidence to make a decision has not been obtained, additional development (e.g., consultative examinations) should be undertaken. Where the signature of the source is needed preadjudicatively, it should, of course, be so obtained.

Where the report is telerecorded, and the signature of the source is not needed preadjudicatively, the DDS, after making a transcription, will stamp and sign on the original copy of the transcribed report a certification that, "This transcription was made from the recording of the voice of
Dr. _____ on _____ (date of contact) ."

An original and two copies of the transcript must be made. The two copies of the transcript should be sent to the medical source with a covering letter which requests review, signature, and return of one signed copy, and advises that a copy which may be kept has been included. The DDS will file the original transcript in the folder.

The covering letter to the medical source should mention to the source that we have prepared a transcript of the medical information provided to us over the telephone and that a copy has been sent for review. Request in the letter that the physician make any necessary additions or corrections and sign and return one copy, along with any previously requested supporting data such as spirometric tracings.

Upon its return, the signed report should be immediately reviewed for consistency and associated with the folder (if in the DDS) or forwarded for folder association (if already sent to the DO or to the reviewing office). In the rare instance where the returned report contains a revision which may affect the determination, the folder should be immediately recalled for further consideration, and, if necessary, a revised determination made or further development undertaken.

2029. Followup On Requests For Evidence

If a reply is not received to an initial request for information within 10 days (unless experience indicates a shorter or longer period is advisable in a particular case) or within a shorter period of time if experience shows that this is feasible, a followup request should be made. If possible, a telephone contact should be made at this point. Where this is not feasible, a followup letter should be sent to the source and the claimant to advise them that this information is still being awaited. When following up with a source in writing, a copy of the followup letter will be sent to the claimant to provide notice that you are having difficulty in obtaining the evidence you need, and that the case may be decided on the basis of the information in file.

If a reply to the followup letter is not received within 10 days (unless experience indicates a shorter or longer period is advisable in a particular case) or within a shorter period of time as dictated by experience, process the case. All followup efforts, whether by mail, telephone or personal contact should be clearly explained in the file so that subsequent reviewers have a clear picture of what efforts were made in documenting the file.

2030. Microfilm or Microfiche Evidence

In obtaining evidence of record, reports may be received from hospitals, institutions, clinics, etc., in the form of microfilm or microfiche. This evidence should be accompanied by a certification by the custodian of the record (i.e., medical librarian, etc.,) that it is a true and exact copy of the microfilm or microfiche on file at the source. Where reproduction equipment is available, the medical evidence contained in the film strip or microfiche should be reproduced into legible copy for folder documentation. Certify on a Report of Contact form exactly which documents in the file were reproduced from the microfilm or microfiche.

In the event that the reproduction equipment is not available, but there is the capability to read the microfilm or microfiche, a Report of Contact should be completed, listing and certifying all the pertinent medical findings obtained from the microfilm strip or microfiche with a full explanation of how the film was read.

If the reproduction equipment is not available, and the microfilm or microfiche cannot be read, request the source or DO parallel to the DDS to provide hard copy reproduction.

Place the film strip or microfiche in an envelope and identify the envelope with the claimant's name, Social Security number, cross-reference SSN, the source of the document, and contents. Prong file the envelope on the right side of the folder.

The folder documentation should be such that an independent reviewer (quality assurance, appellate levels, etc.) will be able to review the folder contents.

2041. Vocational Evidence

When the DDS on the basis of any medical evidence determines that detailed vocational information is necessary, it should first consider the feasibility of securing information directly from the claimant, preferably by telephone. The file must contain complete vocational documentation in all cases (initial, reconsideration and continuing disability) adjudicated under Regulations 404.1520(f) and 416.920(f). See DI 2041.A. concerning curtailment of vocational development in certain initial cases.

Complete vocational documentation consists of a full description of the claimant's work history during the 15 years prior to alleged onset (15 years prior to date earnings test last met, if earlier). NOTE: Although the work evaluated is generally the work performed during the 15 years

exists to support the administrative law judge's action, and stated findings and conclusions. This requires that the decision be based on sufficient quantity and quality of evidence so that a reasonable mind might come to the same conclusion.

In addition, the Appeals Council will review a hearing decision where there is a broad policy or procedural issue that may affect the general public interest. Review for this reason will generally be limited to circumstances in which a decision raises or addresses a question which has potentially far-reaching applicability for a significant number of claims.

The Appeals Council will not ordinarily review a hearing decision where the end result would remain unchanged unless there is a compelling need to do so.

Nothing in this Program Policy Statement alters or affects the Appeals Council's authority to reopen a decision under the rules set forth in regulations sections 404.988 and 416.1488. Under these regulations, the Appeals Council may reopen for any reason any decision within 12 months of the date of the notice of the initial determination. After 12 months, the Appeals Council may reopen a decision for such reasons as specified in the regulations.

The procedures and instructions for staff which provide support to the Appeals Council in performing its review functions are contained in staff manuals.

EFFECTIVE DATE: The ongoing program of comprehensive evaluation of administrative law judge actions within OHA commenced effective October 1, 1981.

CROSS-REFERENCES: Claims Manual sections 7166.4 and 13691.5.

(To be Published as PPS-63)

SSR 82-14

TITLE II AND TITLE XVI: REQUIREMENTS FOR CONSULTATIVE EXAMINATIONS AND TESTS PURCHASED IN CLAIMS BASED ON DISABILITY

PURPOSE: To state the policy on consultative examinations purchased at Federal Government expense in disability claims filed under the Social Security (title II) and Supplemental Security Income (title XVI) Programs.

CITATIONS (AUTHORITY): Sections 223(d)(5) and 1633 of the Social Security Act; regulations Nos. 4 and 16, sections 404.1513, 404.1517, 416.913 and 416.917.

PERTINENT HISTORY: Section 223(d)(5) of the Social Security Act provides, in pertinent part, that an individual shall not be considered to be under a disability unless he or she furnishes such medical and other evidence as the Secretary may require. Under implementing regulations (20 CFR sections 404.1512-404.1518 and 416.912-416.918), determinations as to disability are based on evidence supplied by the claimant's own

medical sources and, where needed, on independent physical or mental examinations or tests purchased at Federal Government expense. Such examinations, referred to as "consultative examinations (CE's)," may be needed in order to: (1) to obtain more detailed medical findings about the claimant's impairments; (2) obtain technical or specialized medical information; or (3) resolve conflicts or differences in medical findings in the evidence already in file.

The regulations, as well as disability operating instructions, clearly intend that evidence obtained as a result of purchased examinations or tests will permit sound adjudication to be made when such evidence is considered along with all other medical and nonmedical evidence submitted in connection with a disability claim. To constitute evidence acceptable for adjudicative purposes, the CE must be performed by a competent physician,¹ and the report must be complete and personally reviewed and signed by the individual who actually performs the examination and/or tests.

POLICY STATEMENT: Consultative examinations and tests purchased in connection with the adjudication of title II and title XVI disability claims must be performed by qualified sources. Those sources and the reports they furnish must reflect the following essential characteristics:

1. **Physician Qualifications**—The physician doing the examination or test must be competent to do so. While the Social Security Administration (SSA) does not require that the physician be a specialist in the medical field in which the examination or test is requested, the physician's qualifications must indicate that he or she is licensed and, in the judgment of the Disability Determination Services (DDS), has the training and experience to perform the type of examination or test requested. The physician's professional conduct and reputation must be such as to avoid an unfavorable reflection upon the government and erosion of public confidence in the administration of the program.
2. **Physician Independence**—All implications of possible conflicts of interest must be avoided. For example, the physician doing the examination or test must not be a full-time or part-time employee of a State DDS or any component of SSA unless there is no other qualified medical resource available. In such instances, the physician cannot participate in the disability decisionmaking or review process on that claim. Also, the physician must not have any familial, financial, or other relationship to the claimant, e.g., as an actual or potential representative payee.
3. **Report Content**—The reported results of the history, examination, pertinent requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a

¹It is recognized that CE's will occasionally be performed by specialists other than physicians such as psychologists, audiologists, etc. In such situations, the guidelines spelled out in this PPS are applicable to the extent possible.

complete and competent examination. SSA recognizes that the detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. Thus, the extent and detail of information expected in a report of a general internal medicine examination will differ from that expected when a neurological, orthopedic, psychiatric, psychological, ophthalmological, otological or other examination is requested to address a specific issue. Moreover, the reporting of information will differ when the requested examination evidence relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. When a complete examination is involved, the report should include:

- a. The major or chief complaint(s) of the claimant.
- b. Within the area of specialty of the examination, a detailed description of the history of the major complaint(s).
- c. A description, and disposition, of pertinent "positive," as well as "negative," detailed findings based on the history, examination and laboratory tests related to the major complaint(s) and any other abnormalities reported or found during examination or laboratory testing.
- d. The results of requested laboratory tests performed according to the requirements stated in the Listing of Impairments (see Regulations Nos. 4 and 16; appendix 1); and the results of other tests (e.g., X-rays of the most involved arthritic joint) that are found necessary as a result of the physician's examination. (Such tests require DDS physician authorization.)
- e. Diagnosis and prognosis.
- f. A medical assessment (except in statutory blindness claims and disability claims for widows and widowers) which shows the claimant's ability to do work-related activities or to function in a work setting.

In addition to the above, the consultative physician must consider, and provide some explanation or comment on, the major complaint(s) and any other abnormalities found during the history and examination or reported from the laboratory tests. The history, examination, evaluation of laboratory test results, and the conclusions must represent the information provided by the physician who signs the report.

4. **Physician Signature**—The physician actually performing the consultative examination or testing must personally review and sign the report; the signature of any other physician or person is not acceptable. This attests to the fact that the physician doing the examination or testing is solely

responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory tests results.²

EFFECTIVE DATE: This policy is effective upon receipt.

CROSS REFERENCES: Program Operations Manual System, part 4, sections DI 2026.B., 2027-2028.

²In some instances, a medical technician or other paraprofessional will contribute to the information (e.g., x-rays or laboratory findings) contained in a medical report. In such cases, the physician signing the report must verify the reported findings and conclusions.

2/19/82

Agenda
 DDS Management Forum Seminar
 "Better Management Through Sharing"
 El Paso, Texas
 March 21-24, 1982

Opening Day (Sunday)

3:00 - 6:00 Seminar registration--Forum staff
 4:00 - 5:00 Conference speakers meeting--Planning committee
 6:00 - 7:00 Cocktail hour
 7:00 - 8:00 Buffet dinner
 8:00 - 8:45 Conference opening remarks. A reflection on the universal plight of managers and the special lot of DDS managers--Ed Davis WA

Second Day (Monday)

8:00 - 8:30 Late registration--Forum staff
 8:30 - 8:45 Housekeeping, review of agenda and how seminar works--Forum staff
 8:45 - 9:15 Introduction--Rhoda M Greenberg, Director, Office of Disability Programs
 Welcoming address--Dale Place TX
 --Introduction to the DDS Management Forum
 --Theme of the seminar, "Better Management in Challenging Times Through Sharing"
 9:15 Topic of the Day: Managing the CE Process--Dale Place TX
 9:15 - 10:30 Panel: "Acquiring, Evaluating, Informing, and Maintaining CE Sources" (Question-and-answer session) Tim Latta OR, Jim Lefler ED, Len Herman OH
 Moderator: Bob Sims AZ
 10:30 - 10:45 Break

10:45 - 12:00	Debate: "Pros and Cons of Open vs. Closed CE Panel" (Q & A session) Glen Swisher, MO, Andy Allen WV	Moderator: Lloyd Moses NY
12:00 - 1:15	Lunch	
1:15 - 3:00	Panel: "Use and Monitoring of Volume CE Providers" (Q & A session) Roland Owens VA, Gary Adams CA, Ken Patton, AR	Moderator: Dale Place TX
3:00 - 3:15	Break	
3:15 - 5:00	Panel: "The Physician's View of the CE Process" (Q & A session) Albert Vickers, M.D., John Uts, M.D.	Moderator: Lloyd Moses NY

Third Day (Tuesday)

8:15 - 8:30	Housekeeping activities		
8:30	Topic of the Day: Managing Under Adverse Conditions--Bob Sims AZ		
8:30 - 9:30	"Managing Under Adverse Conditions"		
9:30	A series of six workshops are presented on aspects of managing under adverse conditions. Three workshops in each series will be run simultaneously, once in the morning and once in the afternoon. Participants choose whichever workshops are of most interest to them and therefore can attend a maximum of four. The closing plenary session of the day summarizes each session.		
9:30 - 10:45	Workshops		
	1	2	3
	"Dealing with claims inquiries" Doug Willman NB	"Effective planning and budgeting under conditions of uncertainty" John Cook MS	"Dealing with media and local politicians" Joe Hickman IL
10:45 - 11:00	Break		

11:00 - 12:15 Workshops

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"Operating the Tier I
QA process under
changing conditions"
Bill Jenkins GA

"Dealing with
claimants,
attorneys, advocacy
groups"
Marie Clark WY

"Improving mean
processing time
in a changing
environment"
Lorraine Cronin MA

12:15 - 1:30 Lunch

1:30 - 2:45 Workshops

1

2

3

"Dealing with claims
inquiries"
Doug Willman NE

"Dealing with
claimants,
attorneys, advocacy
groups"
Marie Clark WY

"Improving mean
processing time
in a changing
environment"
Lorraine Cronin MA

2:45 - 3:00 Break

3:00 - 4:15 Workshops

4

5

6

"Operating the Tier I
QA process under
changing conditions"
Bill Jenkins GA

"Effective planning
and budgeting under
conditions of
uncertainty"
John Cook MS

"Dealing with
media and local
politicians"
Joe Hickman IL

4:15 - 5:00 Plenary session wrap-up of six workshops--

Moderator:
Bob Sims AZ

Fourth Day (Wednesday)

8:15 - 8:30 Housekeeping and clearinghouse activities

8:30 Topic of the Day: Present and Future Concerns--Lloyd Moses NY

8:30 - 10:00 Group discussion: "Works in Progress in Our DDS"
(one speaker for each region)

Moderator:
Lloyd Moses NY

10:00 - 10:15 Break

10:15 - 10:45	Strategic Planning for the Future--Herb Brown TX
10:45 - 12:00	Seminar summary--Bill Vollmer MT Evaluation Plan for future forum activities including the next seminar
	Closing remarks--Dale Place TX
12:30	Adjourn

IMPROVING PROCESSING TIME THROUGH WORK SIMPLIFICATIONLORRAINE CARL
GERRY BRUND

(60 minutes)

I. INTRODUCTION (10 minutes)

- a) Our changing environment
- b) Productivity
 - 1. Commerce Department
 - 2. Preconceptions
- c) OIP/PWS
 - 1. Everybody Wins
 - 2. Definitions

II. EXAMPLES OF WHAT AN OIP/PWS CAN DO FOR YOU (5 minute

- a) Accounts Payable
- b) Obligating
- c) Typing of notifications
- d) C/E Placement
- f) OHA Cases

III. PROBLEM VS. SYMPTOM (5 minutes)

- a) Danger Signals
- b) Distinguishing between a problem and symptom

IV. THE FIVE STEPS TO OIP/PWS (10 minutes)

- a) Preparation
- b) Documentation
- c) Analysis
- d) Synthesis
- e) Implementation and Follow Through

V. GROUP DISCUSSION (30 minutes)

Visual aids, transparencies and overhead projector

MANAGING THE CE PROCESS — JIM LEFLER

"Acquiring, Evaluating, Informing & Monitoring CE Sources"

I. Acquiring CE Panelists

- a. Monitoring new physician lists in state medical directories and new telephone listings.
- b. Monitoring newspapers and medical association journals.
- c. Receipt of new physician announcements from medical groups.
- d. Monitoring medical evidence for high quality reports.

Once a new physician is identified, the best method of recruiting appears to be a direct telephone call with an invitation to join our panel of medical examiners. If the physician is unfamiliar with the program, a brief description is given and questions are invited. A question about having to make decisions of entitlement is frequently encountered and offers the opportunity for more detailed explanations.

Special requirements of individual panelists must be considered so that they may be used as needed.

A special relationship exists with a Family Practice Residency program permitting second and third year residents to perform general medical examinations in select cases. This program is an excellent vehicle for helping to educate the medical community to our needs since many of the residents remain in the state to practice privately. They are subsequently available for general medical examinations and are very helpful in advising their patients and in reporting on their patients.

The Medical Relations Officer is the lead person in acquiring CE sources but has substantial support by the Chief Medical Officer which is of considerable help when peer pressure is indicated.

II. Informing CE Panelists

- a. A basic information package should be imparted at the time of recruitment since the physician's interest is high at that time.
- b. Written matter should be sent soon after the verbal contact giving more detail but not more than one would expect the physician to read.
- c. Precise CE requests continue the informational process.
- d. Review of initial CE reports by the Medical Relations Officer is necessary to assure adequacy and follow-up if reports are not complete as requested.
- e. Examiner telephone calls to the physician are one of the best methods of giving information since the specifics of the problem are discussed rather than the generalities.
- f. Calls in specific cases by medical staff are also extremely valuable in addressing specific issues or deficiencies.

III. Evaluating CE Panelists

- a. Reports from CE panelists should be initially reviewed by the Medical Relations Officer until such time as they are considered adequate for program purposes.
- b. Continuing review is the responsibility of the staff Claims Examiner and Medical Consultant and problems are directed to the MRO.
- c. Quality Assurance is also a referral source to the MRO regarding deficient reports.

IV. Maintaining CE Panelists

- a. A system for even utilization of panelists needs to be monitored so that there are no long, unaccountable delays in referrals. Panelists should be used as regularly as need, scheduling and rotation permit.

Our system provides for review of all CE requests by MRO's to assure that appropriate requests are being made and appropriate sources are being used. CE's are ordinarily ordered by Examiner and reviewed by MRO's before Medical Consultant review and sign-off.

- b. Claimant failures to appear at CE appointments are carefully monitored and if individual panelists are threatened with repeated no-shows, special precautions are taken by examiners to assure the claimant's appearance or that the appointment is cancelled within a reasonable time or that someone else will meet the appointment.

MISSOURI IDS PLAN FOR OBTAINING C/E'S - GLEN SWIFT-SL

We are well aware we must obtain medical information in essentially every disability case. Therefore, there is nothing more important to our work than the obtaining of good objective medical information either from existing sources or by the C/E process.

Because of this fact, we tie the obtaining of medical information into one package in Missouri, i.e. obtaining information from existing sources and purchasing C/E's. We add to that our policy of using all appropriate specialists licensed to practice medicine in the state, provided they will give us the service we require at the price we can pay.

This approach requires complete planning and a lot of work.

We have seven supervisors in our state that are also designated as medical liaison persons. Their assignment is to "plan" (and to see this plan is complemented and carried out). Each of these seven is responsible for a geographic area of the state and for seeing that the several counselors that serve that area conduct the medical relations activities in accordance with agency policy and procedures and do in fact completely cover the assigned area.

We assign each of our counselors to serve a specific geographic area of the state. We expect that counselor to become thoroughly familiar with the medical sources in that area as well as other important citizens.

We expect our counselors to do out of office work approximately one day each week, mostly with medical sources.

Through our contacts we accomplish several things:

- 1) We learn each physician's work hours and habits so we know when is best to contact either personally or by phone.
- 2) We learn what equipment they have and the kind of records they keep (so we know what to ask for).
- 3) We learn where they refer their patients when referral is necessary (to try to send applicants for exams where their physician would send them).
- 4) We find out if they are interested in doing exams for us (what exam they are qualified to do); if so, we provide reporting guides (take copies); we impress upon them reports must follow guides.
- 5) We request suggestions as how we may, by working together, best meet the needs of the physician's patients who apply for disability benefits.

This process keeps us adequately provided with C/E physicians while it keeps the practicing physician abreast of our program and its needs.

There are more than 6000 practicing physicians in the state; however, we find we have contact with only about 1/3 or 2000 - why?

Many physicians do not see or examine disability applicants - exclude (1) medical school staff, (2) anesthesiologist, (3) radiologists (many), (4) obstetrician-gynecologist, (5) many surgeons, (6) certain physicians whose clientele don't apply (top social economic group).

By breaking our state down into the small segments covered by a counselor it is no problem to determine which doctors to see and which ~~are~~ not to bother with.

Direct mail distributions go to all physicians.

This plan works well provided it is carefully supervised and is worked continually.

Presentation Outline
 "PROS AND CONS OF USING VOLUME PROVIDERS"
 "MONITORING VOLUME CE SOURCES"
 Gary G. Adams, Administrator, California IDS

- A. INTRODUCTION
- B. BACKGROUND DATA - CALIFORNIA IDS
 - 1. General Statistics
 - 2. Field Office Locations
 - 3. Personnel Involved In The CE Process
 - 4. Composition Of The CE Panel
 - 5. The Rotation Approach To CE Referrals
- C. THE VOLUME PROVIDER
 - 1. Definition Of The Volume Provider
 - 2. Medical Evaluation Centers
- D. ADVANTAGES OF USING VOLUME PROVIDERS
- E. DISADVANTAGES OF USING VOLUME PROVIDERS
- F. CONCLUSIONS ON THE USE OF VOLUME PROVIDERS
- G. THE MONITORING PROCESS
 - 1. What Is Monitoring?
 - 2. Personnel Involved In Monitoring
 - 3. Approaches Used To Monitor Volume Providers
- H. COMPLAINTS
 - 1. Initial Actions
 - 2. Complaints From Providers
 - 3. Complaints Against Providers
 - 4. Resolution Of Complaints
- I. METHODS TO REDUCE THE INCIDENCE OF COMPLAINTS
 - 1. Procedures Used With Provider Initiated Complaints
 - 2. Procedures Used With Claimant Initiated Complaints

"Dealing with Claimants, Attorneys, Advocacy Groups"----- MARIG CLARK

Our objective in conducting this workshop is to open dialogue in this area which presents a variety of issues and problems for DDS managers. We hope to present viewpoints from representative agencies and we ask that you share your perception of these matters, their impact on your operation, and how you may have resolved them.

I. Human Interaction

- A. Development of additional dimension: interpersonal skills required of Disability Examiners.
- B. Communication by telephone, letter and in person.

II. Understanding the Reality of the Claimant/Beneficiary Situation.

A. Contacts at Initial Level

- 1. Minimum anxiety reaction - interaction seen as "assisting" toward getting a benefit.
- 2. Minimum contact with Representatives/Advocacy Groups.

B. Contacts at Reconsideration Level

- 1. Anxiety is heightened - interaction may be seen as obstruction to benefit. Opportunity to educate/inform.
- 2. Claimant may question the credentials of signatories on 831.
- 3. Non-attorney rep/advocacy group may intervene, but contact is still minimal at this level.

C. Contacts at Continuing Disability Investigation

- 1. The 454(a) "threat"
- 2. The problem of cooperation
- 3. Furnishing "due process"
- 4. Third party intervention

III. Representatives/Advocacy Groups

- A. Attorneys - problems in dealing with legal professionals who do not understand the law.
- B. Non-attorney representatives - problems dealing with relatives, friends, bar-stool buddies.
- C. Advocacy Groups - they can become agency advocate as well. Need for promoting understanding and cooperation.

IV. Management Obligations to DDS staff

- A. Screening and training for public contacts.
- B. Assessing need for safety precautions.
- C. Dealing with threats - ways to defuse
- D. Other

DDS MANAGEMENT FORUM
Workshop Outline

"Dealing with Claims Inquiries" - Doug Williams

This workshop is intended as a general presentation and discussion on the subject of claims inquiries received during and after case development and adjudication. The following outline is provided as a starting point for discussion, and the workshop is not limited to the items contained in the outline.

- I. Considerations Based Upon the Source of the Inquiry
 - Claimants
 - Attending Physicians
 - Reporters
 - Attorneys
 - Elected Officials
- II. Considerations Based Upon the Stage of Case Development
 - Initial Development of Evidence of Record
 - Consultative Examination Pending
 - Denial Notification Sent
- III. Appropriate Level of DDS Response
 - When Should the Examiner Handle the Response Independently?
 - When Should the First Line Supervisor Get Involved?
 - When Should Higher Management Respond?
 - When Should DDS Seek Outside Help?
- IV. Privacy Act Considerations
 - Telephone Inquiries From Claimants: What Proofs of Identity are Required?
 - Third Party Inquiries: What Proofs of Consent are Required?
 - Release of Records to Claimants
- V. Unusual Problems in Telephone Contacts
 - The Angry & Hostile Claimant
 - Threats of Violence (see attachment)
 - Threats of Suicide (see attachment)
- VI. Personal Visits by Claimants
 - Privacy Considerations
 - Security Considerations
- VII. Miscellaneous Problems
 - The Persistent Inquirer
 - Anonymous Tips & Complaints

DISABILITY DETERMINATIONS SECTION
DIVISION OF REHABILITATION SERVICES
Department of Education
Memo

March 10, 1982

TO: All Disability Determination Staff
FROM: Doug Willman *DW*
RE: Procedures For Handling Threats
SOAP Action Note #82-9

Recently, there seems to have been a nationwide increase in the number of threats made by claimants towards disability determination staff. There have been a few instances of direct threats to our staff in both our Omaha and Lincoln offices. Therefore, it is prudent to reissue our general guidelines regarding appropriate actions to take if confronted by a threatening situation. These guidelines were previously distributed in September of 1980.

Usually, the threats will fall into one of three types: a vague threat; an immediate and specific threat to your personal well-being; and a bomb scare. In general, all such threats should be taken seriously, and the following actions are recommended.

A vague threat will be the one most likely encountered. An example would be a statement by a claimant, usually made over the telephone, such as "you'll be sorry if I don't get my money", "I'll get even with anyone who does me out of what I deserve", or "I'd better get my benefits or else", etc.. Abusive and foul language also falls into this category. In these cases, try to be as patient with the claimant as possible. Usually, they are simply upset and can be calmed down. If the claimant's language is profane or abusive, advise him/her that you would like to hear and respond to their concerns, but that you will not permit abusive language and that use of the next profanity will end the conversation. If the profanity is repeated, hang up. If a vague threat is involved, you should make a statement such as the following:

"What you have just said was a threat and may be a crime under Nebraska law or federal law. My supervisor requires that I report all clear threats to the proper authorities, so please don't threaten me anymore."

In many cases, this statement will cause the threats to stop. If they persist, advise the claimant that the conversation will be reported, hang up,

and report the situation to your supervisor. If the claimant demands to speak to your supervisor, transfer the call to the Unit Supervisor (in Omaha), or the Unit Supervisor or Program Administrator (in Lincoln).

The second type of threat is the most dramatic. A statement such as "I am going to come down to your office with a gun" or "you won't get home tonight" falls into the category of an immediate threat. If the threat is made over the telephone, make the statements given in the paragraph above, and write down exactly what the claimant says. After you have hung up, notify me or your supervisor of the incident. If no supervisor is available (if you are working on an evening or weekend) call '911' and report the incident. Then call building security at 471-2400 in Lincoln and 554-2116 in Omaha. It is important to document what was said so that the statements can be reported accurately to the authorities. If the threat is given by a claimant actually in the office, try to remain calm and stall for time. **DO NOT PHYSICALLY CONTACT THE CLAIMANT UNLESS NECESSARY FOR SELF-DEFENSE.** Our work setting is such that the threat will undoubtedly be overheard by a co-worker. When you overhear such a threat, you should quietly advise me or your supervisor, and the authorities will be contacted so that they can apprehend the claimant before he leaves the office. Again, write down exactly what you heard. When talking to the claimant, repeat the statements mentioned earlier, i.e. he/she may have committed a crime. Advise them that it is never a good idea to threaten anyone because if something were to happen to that person, they would be the prime suspect. If the person demands to see your supervisor, bring them to my office, and then quietly alert the authorities by calling '911'.

The final threatening situation is a 'bomb scare'. The department has established procedures to handle such instances. A bomb threat will usually be given over the phone. Again, write down exactly what was said. Report the incident to your supervisor. In the Lincoln office, Nancy Riley has been named the person responsible (Lois Gossard is alternate) to handle fire and bomb threat situations. You should look around your immediate area and report any suspicious items to the floor captain or your supervisor. **DO NOT TOUCH THEM.** The Fire Chief or officer-in-charge will make the decision on whether or not the building should be evacuated. If it is, remember to not turn off any electrical equipment, not lock your desk, file cabinet, doors, and do not use the telephone. If you are alone in the office, report the incident to the security desk and leave the area without touching anything.

Please feel free to ask me any questions you may have regarding this memo. The important things to remember in any threatening situation are to remain calm, document what is said, and report the incident as soon as possible to your supervisor or the authorities.

If you still have the September 29, 1980 memo on this subject, please discard it. File this memo in Chapter 16 of your SOAP Manual.

/mhh

DISABILITY DETERMINATIONS SECTION
DIVISION OF REHABILITATION SERVICES
State Department of Education
Memo

February 22, 1982

TO: All DDS Professional Staff

FROM: Doug Willman, Program Administrator DW

RE: Guidelines on How to Handle Suicide Threats
SOAP Action Note #82-7

At the training session held January 19th, 1982, the subject of how to handle threats of suicide by claimants was brought up, and considerable discussion was held. Although having a claimant threaten suicide is hopefully a rare occurrence, it is important to know how to handle such a threat when it is received. Because DDS examiners are not generally trained as professional counselors, it is advisable that examiners do not attempt to 'counsel' a claimant when a threat of suicide is made. Instead, the following guidelines are being offered so that examiners have some instruction as to what they should do.

I. The Examiner's Role:

1. Relax. Do not introduce additional unnecessary stress into the situation by becoming upset yourself. Remember that most persons who threaten suicide really want to live and are asking for help from the listener in identifying another alternative. There are things you can do, but your power and responsibility are limited.
2. Listen calmly and carefully, without challenge or criticism.
3. Try to identify the actual level of suicide risk present. (See II. following).
4. If the risk appears very high (on the basis of either of the two tests in Part II), the examiner should take one of the following actions immediately after talking to the claimant:
 - a. If the person has already taken action or is threatening suicide immediately (i.e., has swallowed a bottle of pills), try to confirm the person's location and notify your supervisor and the appropriate law enforcement agency immediately.

SOAP Action Note #82-5
 February 10th, 1982
 Page Two

- b. If the person appears to be contemplating suicide seriously but the danger is not imminent, you should then contact the nearest mental health assistance source - a list of sources by area is attached. Also notify the person's physician, a close relative, or other appropriate person obtainable from the case file that the claimant has threatened suicide and that you feel someone close to the claimant should make personal contact immediately.

When notifying a third party of the claimant's action or threat, it is important to keep in mind the claimant's right to privacy. Fortunately, this does not present an insurmountable problem because we are required to primarily protect the confidentiality of the fact than an application has been filed and the facts regarding the application. Threats made in conversations incidental to handling the claim are not the emphasis of our concern about privacy. Therefore, when reporting the threat or action to a family member, physician, law enforcement agency, or other party, the examiner should report only what the claimant has said or done. It is not necessary or desirable to inform the third party about our relationship with the claimant, or the fact that a disability application was filed.

II. Level of Suicide Risk

A. Following are examples of some reasons which may motivate persons to threaten and/or attempt suicide, with the level of risk increasing with each example. These examples are only being presented to assist the examiner in evaluating the level of risk present when a claimant threatens to commit suicide. However, each individual case is different and the risk in any case will increase when the person is actively using alcohol or drugs, has attempted suicide previously, has had someone in the family, such as a parent commit suicide, etc. Examiners should remain calm when a suicide threat is made, and listen to try to evaluate how serious the threat is. A claimant may threaten suicide because:

1. The claimant is simply angry and doesn't have any intention of committing suicide or doing any other thing that he or she is likely to say in anger. Anger is usually indicated by shouting, rapid speech, insulting remarks, etc. Calm listening will usually calm the claimant and the threat of suicide will be forgotten.
2. He/She is trying to manipulate the examiner and make the examiner feel responsible for what happens to the claimant.

SOAP Action Note #82-5
February 10th, 1982
Page Three

3. An expression of self-hate in which dissatisfaction is directed inward rather than toward others.
4. A reflection of distress at the present situation. An expression of confusion about not knowing where to turn.
5. An expression of final despair. In this case, speech may be slowed and may have comparatively little inflexion. The content may be fixed solely on the hopelessness of the situation.

Any of the last three reasons for threatening suicide should be considered serious, especially in the presence of other motivators such as alcohol or drugs, or personal problems such as indebtedness or recent divorce. If the claimant's initial statement is too brief to give adequate clues about the degree of seriousness, the examiner may ask some leading questions such as "I know that things are very difficult for you now, but I can't believe you would do that. What would you accomplish? Isn't there another alternative?", or "I can tell that you are very upset and are understandably having trouble coping with all of your problems. Have you considered contacting the mental health center near you for help?". The examiners should use their own judgement, but the answers to questions such as these will help in evaluating the level of risk.

B. At some point in the conversation, you should indicate that you are required to report all serious threats of suicide to the police or other authority. If the claimant persists with the threat after this statement, then the threat should be considered serious and a report should be made to a third party.

As stated previously, do not attempt to analyze or "counsel" the claimant. DO NOT ask questions such as "Do you have a method?" or "Have you decided when you might do this?" These questions might further catalyze a suicide. The examiner's role is one of appropriate concern and referral. Possible referral agencies and phone numbers are listed on the following page. If none of the listed options are viable, contact "Hotline for the Handicapped" for a more extensive listing of available sources. In addition, Maureen Harvey has a booklet listing Nebraska Mental Health Services.

III. Documentation

After the conversation has ended and any necessary action has been taken, carefully document the conversation. Place a copy in the case file and forward a copy to your immediate supervisor and to the Program Administrator.

Please file this memo in Chapter 16 of your SOAP Manual.

SUICIDE REFERRAL AGENCIES

Lincoln Area:	Lincoln Personal Crisis Service (24-hour availability)	402/475-5171
Omaha Area:	Omaha Personal Crisis Services (24-hour availability)	402/444-7335
Scottsbluff:	Panhandle Mental Health Center (24-hour availability)	308/635-3171
North Platte:	Great Plains Mental Health Center (8-5, M-F; 6-9 pm. Th.)	308/532-4050
Grand Island:	Mid-Nebraska Community Mental Health (9-5, M-F)	308/381-5250
Norfolk:	Northern Ne. Comp. Mental Health (24-hour availability)	1-800-672-8323
Beatrice:	Blue Valley Mental Health Center (9-5, M-F)	402/228-3386

STATE OF ARKANSAS

Disability Determination For Social Security Administration

701 PULASKI STREET
LITTLE ROCK, ARKANSAS 72201
TELEPHONE 801 371-3030

HIGH VOLUME CE PROVIDERS

A. Disability program objectives

1. Provide benefits to the correct person
2. Quickly as possible
3. At the least expense
4. Quality decision

B. History of the CE rates

1. Making determinations - Evidence of Record
2. Making determinations - Consultative Exams

C. Reasons for using volume providers

1. Processing time
2. Consistent reports
3. Quality reports

D. Reasons for not using volume providers

1. Reports are standardized
2. Applicants and other groups develop feeling it is a SSA M.D.
3. Volume provider - employee-employer relationship
4. Alienation of M.D.'s in the medical community; same people we try to get evidence of records from
5. Finding M.D.'s to devote time
6. Time spent on the exam

3. Monitoring of volume CE sources in Arkansas

1. Time of CE receipts
2. M.D. or D.D.S. examiner review

F. Status of volume CE sources

1. Highest volume source less than 4% of CE budget
2. State law requires contract approval by Legislature Council of General Assembly

6. Possible consequence of volume CE sources for long provider

1. Federal exam station; like Veterans Administration and compensation and pension exams
2. Relying on a single source; then if it for some reason stops, you're having to go to a potentially hostile medical community for help.

Managing the C.E. Process

Specific Topic: Acquiring, Evaluating, Informing and Maintaining C.E. Sources

A) Acquiring - Continuous activity rather than action initiated at time of specific need.

- 1) Solicit recommended names from in-agency physicians
- 2) Canvass universities and hospitals
- 3) Solicit possible recommendations from supervisory and examiner staff
- 4) Participation in convention and other professional organization meetings
- 5) Advertisements in medical journals and other local medical publications.
- 6) Saturation mailing to specific areas
- 7) Solicit recommendation from current consultants
- 8) Direct contact from physician with interest
- 9) Arrange for a physician to travel to area of need
- 10) Continuous inquiry by medical relations staff during their contacts while traveling through state

B) Evaluating

- 1) Intense initial evaluation on following administrative guides, completeness and time
- 2) Ongoing by medical administration, in agency physician or examiner staff
- 3) Ongoing timeliness record

C) Informing

Immediate feedback on problems by medical administrator, chief consultant or medical relation staff. Followed by period of closer monitoring.

D) Maintaining

Address problems quickly, investigate complaints, stay in communication

DEALING WITH MEDIA AND LOCAL POLITICAL FIGURES

Norval J. Hickman, Jr.

I. Introduction

Recent amendments to the Social Security Act requiring: Periodic Reviews of existing claims, Personalized Denial Notices and changes in the SSA/RSA Rehabilitation Funding Policy and Procedures have resulted in an increase in the amount of contact State DDS's have experienced with the media and local/State political figures.

Additionally, publicity surrounding the use of high volume medical sources have also spotlighted the DDS's and the claims adjudicative process.

For many years the DDS's contacts with these entities were limited to congressional inquiries, i.e. requesting that consideration and information about a specific claim undergoing adjudicative process, and/or a local newspaper story concerning a local resident who had questions about the correctness of the decision made on his/her claim.

However, the nature of these contacts have changed and now every aspect of the claims adjudicative process is under question and subject to investigation by either the media or political figures. The DDS' often finds themselves the first line contact by individuals who have questions about the every aspect of the adjudicative process to include not only the State Agency's role, but that of Central Office, Regional Office, and the Bureau of Hearings and Appeals. The State Agency not only must explain its unusual statutory position in the contexts of its own State Governmental System, but its relative position within the Social Security Administration, Office of Disability operations.

II. Discussion Topics

- Examples of questions most often posed to the DDS
- Format in which these questions are received, i.e. letter, telephone contact, personal visits, etc.
- Types of responses produced
- Receptiveness of response by inquirer
- Time spent by DDS developing responses, i.e. staff time, research time, contacting Central Office/Regional Office, etc.
- Accuracy of inquirer by reproducing the information provided by DDS
- Degree, if any, of political pressure experienced by the DDS.

III. Discuss: Role of DDS Administrator in Dealing with Media and Political Figures

OPENNESS: Discussion: Being non-defensive - receptive to an exchange of communication and information. Attitude must be positive.

ESTABLISHMENT OF GROUND RULES: Discussion: Do not discuss specific claim unless have signed release forms. Discuss areas under ones responsibility and control.

EDUCATION: Discussion: Explain State/Federal History/Relationship - Role of DDS in claims adjudication process - Roles of Sub-Unit within the DDS. State Agency role in State Government.

MANAGING THE TIER I PROCESS
UNDER CHANGING CONDITIONS

- I. Historical summary of the QA Process.
Brief summary of the origins of process and the problems encumbered in implementing it.
- II. Current QA Process
Description of one agency's modification of the process in response to the 1980 Amendments.
- III. Application of management principles to the QA process
Identifying goals, establishing controls, monitoring impact and effectuating change.

OPERATING THE TIER I QA PROCESS UNDER CHANGING CONDITIONS

I. Welcome and presentation of plan for the workshop.

I would like to take this opportunity to welcome you to this particular workshop and hopefully as a result of your attendance and participation, we will be able to come out with some useful information and some ideas that will better enable us to utilize our Quality Assurance process to maximum advantage and accommodate whatever changing conditions we may have to face.

II. I think I would like to mention a little bit of history of Quality Assurance and look back at where we have been in QA.

When QA started some 10 or 11 years ago, we had to make some management decisions about Quality Assurance and some decisions were forced on us. I think we had to determine pretty well what the mission of Quality Assurance was (and this changed.) I think we had to determine where it fit in our organization functionally. I think we had to make a determination as to whether or not the Quality Assurance people were going to be at the Senior Disability Adjudicator or at a higher paygrade level. I am sure you all had to make a decision as to what level the supervisor of the Quality Assurance could be on. If you had a decentralization agency, decentralization of QA versus centralization was a decision that you had to make. In our instant case, I think it would be safe to say that during the years, we went through an experience with Quality Assurance as perhaps each of you did

in trying to determine whether or not we were talking about assuring quality or operating a quality control system, and there is a difference. We made many mistakes in selecting people early on to go into Quality Assurance and ultimately had to select the type of people with capability and personality to do the job that needed to be done. We had a serious selling job on our hands with classification people in getting the paygrades at an acceptable level to attract the better people. Many times, I personally raised the question as to whether or not Quality Assurance was an asset or an liability, and many times, I would have been willing to sacrifice Quality Assurance and put it in complete oblivion because of some of the thorny problems that it caused in managing the program. I hasten to add, however, that anything worthwhile comes with a price, and I think any of us who have been around a while can look back at the growth and evolution and direction of Quality Assurance, and I doubt that there would be anyone in this audience that would attempt to manage a State Agency without the benefit of a Quality Assurance Section.

III. This leads us to the question of where we are now in Quality Assurance.

As most of you know, the 1980 Amendments does preserve by regulation our appeal for a continuation of the Quality Assurance function at the State Agency level. We now pretty much have the freedom to utilize QA as a management tool in whatever way is best suited for our agency. I expect that most of us

may in general, be doing what we have been doing in the past with QA with some special modifications to suit our own management needs. In our agency, we are currently reviewing a QA sample that consists of 1 in 30 initial cases, 1 in 15 recon cases, and 1 in 10 CDI cases selected by interval sample. The results of this case review is reported on a monthly and a quarterly basis by unit, district, and agency. In addition, we are also reviewing several categories of high risk cases including all cases returned from any level of federal review, that is (DAB and ODO), and cases falling in the special sense body systems which receive the full Quality Assurance case review. Some other categories of high risk cases, such as all allowed cases and recon affirmations, are subjected to only limited review consisting of emphasis on decisional, documentation, onset, cessation dates, letter notifications and a few other points considered vital along with some less important technical items. All cases that are not subjected to the full review process are included in 100% technical review by the secretarial staff of QA. We are now averaging reviewing about a 1,000 cases a month of which two-thirds are nonsample, high risk cases, and this is our projected review workload on an ongoing basis. We do not do 100% front end medical review as our full time consultant is required to spend all of his time reviewing problem cases brought to his attention by the QA staff. Our QA unit is also heavily involved in training and many of the QA Specialists are involved in all facets of training. As a matter of fact, one of our QA Specialist is acting as Assistant Training Officer, which is a backup position.

In addition, as I mentioned earlier, we are processing through QA all ODO and DAB returns that go to and from the agency where fairly extensive records are kept on these type cases. There are many other activities that QA is involved in including duplicating of the medical information and record keeping, and routing on all cases referred to V.R.; securing the cases from the Operations' units or counting, selection and sample reviewing; and perhaps as important as any other function, serving unofficially as a pool for case consultation by unit supervisors and district directors, for consultation, advice, and general staffing. There are several studies for management that are going on from time to time of a special nature which I am sure each of you depend on QA to do for you to satisfy your particular need.

IV. All of this brings me to the real question and purpose of this workshop, and that is to try to predict or be futuristic as to where we are likely to be in the QA process under the changing conditions that we will be required to manage in the future.

At this point, I cannot predict what changes will occur, but you and I know that we can predict that we will be managing in a constant environment of change in the future. We will likely feel some external pressure or be persuaded to have our own QA review an increased number of cessations and denials since most SSA review is mandated towards the favorable decisions and their resources are limited. The consensus of thinking in the Atlanta Region as to proper future activities of our QA units are:

- 1) Provide feedback to management on particular issues or staff members regarding performance in areas related to quality;

- 2) Identify training needs;
- 3) Monitor development practices;
- 4) Monitor implementation of new policies and/or procedures;
- 5) Monitor corrective action taken as the result of federal review of SSA-831's and SSA-833's;
- 6) Perform technical review of SSA-831's and SSA-833's;
- 7) Act as a policy clearing-house for the agency and resolve policy questions from existing references or through DPB contact;
- 8) Report on trends in SSA-1774 returns;
- 9) Perform special studies as needed;
- 10) Oversee manual sampling activities.

I don't think that there is any question but what fiscal scarcity will touch us before long and who among us will admit that they have never looked at QA (at least fleetingly) as a ready source of manpower in a time of acute crisis where any and all additional help was desperately needed in Operations.

I think it is also incumbent on us to be constantly aware of how much manpower and money and resources, including medical resources that it takes to operate our individual QA sections. In our case, it takes 8 QA Specialists, 1 Unit Supervisor, 1 full time Medical Consultant, 8 Clerical workers, 1 Clerk Supervisor, and over \$370,000 a year to operate QA.

I think the question that we must periodically ask ourselves "is the investment really paying off and making a difference in our overall operations and insuring or assisting in the assurance of a quality product"? In Georgia, we believe that true quality can only be achieved at the lowest operations level and Quality Assurance can at best only monitor our progress and assist us in identifying areas of strength or weaknesses that we need to hone in on.

and follow up with appropriate change. I think that we as Administrators, who are responsible for Quality Assurance, must insure that we are properly controlling this area of our management responsibility, so that planned for performance will be performed or accomplished effectively, efficiently, and economically. I believe that in order for us to manage change as it affects our agency and our Quality Assurance sections efficiently, it would be very appropriate for us to review four critical concepts related to effective management control, which I believe we need to clearly understand in order to be more skillful at exercising management control as related to QA.

First, we must have an ongoing monitoring of the functions and activities of QA to insure that the actual performance corresponds with the planned performance that we expect and the prompt execution of appropriate corrective action when our monitoring indicates significant deviation from what was planned.

Second, I believe that we must clearly identify what should be monitored, what should be reported, and what the reporting frequency should be. Are you being overwhelmed with meaningless statistical reports from your QA Section?

The third very critical element in QA management control concerns the setting of a proper degree of control which is neither too loose or too tight. We must somehow try to strike a proper balance between too loose control and an overly tight control.

The fourth is recognition that a control system has impact on people and may motivate all sorts of inappropriate behavior. In the management of QA, we must always be very careful to insure that the method and manner of controlling does not trigger undesirable

human relationships. We must know that the potential is always present in an unique way in QA. I'm really saying that the management of our QA Section requires at least the same if not more management and control as does any other facet of our organization. We make our plans, usually based on certain assumptions and these assumptions require close monitoring for prompt adjustment in the event that our early assumptions need changing, such as workload shifts, availability of resources, etc. We must monitor and control in the area of goals and objectives. Yes, in my judgment, QA should have specific goals, even in terms of productivity and quality, just as any other facet of our organization. Appropriate detailed action plans also provide another effective QA control mechanism and an opportunity to intergrate QA functions with the overall management of the total DDS program. No doubt we expend a great deal of energy controlling financial resources, case production, medical resources, etc., but often overlook perhaps as equally a critical organization resource which is the people who do the organization's work. We know that their attitude toward work, their productivity, their quality and quantity of their results should be monitored, and appreciated as carefully as the expenditure of funds. I think we often have a tendency to focus our management attention on the operations aspect of our work with the consequence that the control of the Quality Assurance routine is easily neglected.

In closing, then I say that whatever the climate we are in, we must apply good management practices to QA, just as carefully as we do to any other part of our organization. We must let our QA people know that we have definite plans, goals, and expectations

from them which are monitored and at every opportunity support and recognize them as an integral and important part of management. Now let us have an open discussion as to some of the things you are doing in QA that you consider innovative and your ideas of how you view the QA process and how you plan to manage it.

SUMMARY OF REMARKS TO DDS MANAGERS

PRESENTED MARCH 22, 1982 ✓

BY

A. J. ALLEN

WEST VIRGINIA DISABILITY DETERMINATION SECTION

SUBJECT: A CASE FOR A CLOSED C/E PANEL

1. A closed panel is comprised of a smaller number of physicians thereby:
 - a. Enhancing opportunity for training consultants regarding program documentation requirements.
 - b. Insuring greater program interest on the part of the C/E physicians.
 - c. Maximizing your ability to negotiate fees and control growth in medical costs.
2. A closed panel is more tolerant of program changes, special requirements, and needs.
3. A closed panel increases your capacity to secure block time, thereby facilitating scheduling, i.e. - it is easier and faster to schedule 100 claimants with 1, 2, 3, 4, or 5 sources than it is to schedule the same number with 10, 20, 30, or 100 sources.
4. A closed panel is comprised of physicians more alert to unidentified problems and the need to resolve them.
5. A closed panel requires less direction on the part of the S/A medical consultant and/or examiner.
6. A closed panel lowers cost by reducing the amount of unnecessary laboratory work, x-ray, and other tests and procedures.
7. A closed panel eliminates many repeat examinations, thereby reducing cost for examinations, applicant travel, telephone, postage, and personal services.
8. A closed panel significantly reduces processing time.



PRO'S AND CON'S OF USING VOLUME VENDORS -ROLAND OWENS

I APPRECIATE THE OPPORTUNITY TO DISCUSS WITH YOU FOR THE NEXT FEW MINUTES THE SUBJECT OF VOLUME VENDORS. AS MOST OF YOU ARE AWARE, THE CURRENT ATTENTION BEING GIVEN TO THE SUBJECT OF VOLUME VENDORS ORIGINATED IN A FEDERAL DISTRICT COURT IN SOUTHWESTERN VIRGINIA WHERE A FEDERAL JUDGE CHARGED THAT THE CONSULTATIVE EXAMINATION REPORTS OF A GROUP KNOWN AS SUBURBAN INTERNAL MEDICAL GROUP APPEARED TO BE CURSORY AND FRAUDULENT IN NATURE. THIS PARTICULAR GROUP WAS CONDUCTING CONSULTATIVE EXAMINATIONS IN A NUMBER OF STATES, INCLUDING VIRGINIA.

THE ISSUE DEALING WITH DDS'S USING VOLUME VENDORS APPEARS TO BE PYRAMIDAL IN NATURE. DDS'S ARE CHARGED WITH THE RESPONSIBILITY OF MAKING FAIR AND TIMELY DECISIONS. AGAIN, AS YOU ARE AWARE, THE DEFINITION OF FAIR AND TIMELY DECISIONS IS PRESCRIBED IN FEDERAL REGULATIONS. IN OUR ATTEMPTS TO REACH FAIR AND TIMELY DECISIONS, SEVERAL IMPORTANT STEPS MUST BE CONSIDERED INCLUDING THE CE PROCESS. THE CE PROCESS HAS EVOLVED THROUGH THE LAST SEVERAL YEARS AS A RESULT OF TITLE XVI, INCREASING WORKLOADS IN TITLE II, THE EMPHASIS ON QUALITY, AND NOW PERIODIC REVIEW. OUR CONSULTATIVE EXAMINATION PANELS HAVE INCREASED AND IN FACT BEEN STRETCHED IN MANY INSTANCES ALMOST TO THE BREAKING POINT IN OUR ATTEMPTS TO ACHIEVE AND MAINTAIN FAIRNESS AND ACCURACY. IN OUR EFFORTS TO MEET THE INCREASING NEED FOR CE'S, MANY OF US HAVE MADE INCREASING USE OF SO-CALLED VOLUME SOURCES. SINCE THERE IS NO CLEAR DEFINITION OF A VOLUME SOURCE, MY REMARKS ON THE PRO'S AND CON'S OF USING VOLUME SOURCES WILL BE GEARED PRIMARILY TO MY OWN DEFINITION. THAT DEFINITION IS A SOURCE WHO SPECIALIZES PRIMARILY IN DOING DISABILITY EXAMINATIONS AND A SOURCE WHICH DOES A SIGNIFICANT NUMBER OF EXAMS FOR THE DISABILITY PROGRAM.

ON THE PRO SIDE OF THE LEDGER, FIRST, THE EASE OF ADMINISTRATION. IT IS MUCH EASIER TO SCHEDULE SEVERAL EXAMS WITH ONE SOURCE THAN TO SCHEDULE SEVERAL EXAMS WITH SEVERAL SOURCES. SECONDLY, IT IS MUCH EASIER TO MONITOR QUALITY OF ONE SOURCE THAN IT IS TO MEASURE THE QUALITY OF SEVERAL SOURCES. THIRD, A VOLUME SOURCE IS MUCH MORE FAMILIAR WITH DISABILITY REQUIREMENTS AND REPORTING NEEDS. FOURTH, A VOLUME SOURCE HAS THE ABILITY TO LOCATE IN AN AREA WHERE THERE ARE FEW OR NO OTHER PHYSICIANS TO PERFORM CE'S. THIS ALSO ASSISTS IN REDUCING APPLICANT TRAVEL.

ON THE CON SIDE OF THE LEDGER, FIRST AND FOREMOST, PERCEPTION. THE PERCEPTION OF OUR CLIENTELE, THE LEGAL COMMUNITY, AND IN SOME INSTANCES THE EXISTING MEDICAL COMMUNITY IS NEGATIVE. VOLUME SOURCES ARE VIEWED AS ASSEMBLY LINE PRODUCTIONS OF MEDICAL REPORTS WITH LITTLE CONCERN FOR THE PATIENT. THE VOLUME SOURCES' USE OF CHECK SHEETS, PARA-PROFESSIONALS, WORD PROCESSING EQUIPMENT, ETC. IS VERY SUSPECT. ALLEGATIONS THAT THE PHYSICIANS SPEND LITTLE TIME IN THE ACTUAL EXAMINATION OR BEDSIDE MANNER OF PHYSICIANS, AND OF COURSE THE ONGOING CONCERN THAT THESE GROUPS ARE GETTING RICH OFF OF THE DISABILITY PROGRAM COMPOUND OUR PROBLEMS. SECONDLY, WE IN VIRGINIA HAVE EXPERIENCED A SPILL-OVER OF THESE PERCEPTIONS ON MANY OF OUR LONG-TERM CONSULTATIVE EXAMINATION PANELISTS AND IN SEVERAL INSTANCES THESE SAME NEGATIVE PERCEPTIONS HAVE BEEN USED IN AN ATTEMPT TO DISCREDIT THEIR REPORTS.

AT BEST, IT WILL BE VERY DIFFICULT TO OVERCOME THESE PERCEPTIONS. IN VIRGINIA, AS A RESULT OF THE LOSS OF TWO SO-CALLED VOLUME VENDORS, WE HAVE LOST APPROXIMATELY 140 CE SLOTS PER MONTH IN OUR SOUTHWESTERN

REGION. IN ORDER TO COMPENSATE FOR THIS LOSS, WE SURVEYED THE ENTIRE MEDICAL COMMUNITY IN THAT PARTICULAR AREA OF THE STATE. WE WERE ONLY ABLE TO RECOUP 40 OF THE CE SLOTS GIVING US A CONTINUING NET LOSS OF 100. WHAT CAN BE DONE TO SAFEGUARD THE USE OF VOLUME VENDORS?

(1) ATTEMPT TO ASSURE OUR CLIENTELE AND ANY OTHER INTERESTED PUBLIC THAT VOLUME SOURCES WILL BE USED ONLY IN THOSE AREAS WHERE THERE ARE NOT SUFFICIENT CONSULTATIVE EXAMINATION SOURCES. (2) DDS PERSONNEL SHOULD CONDUCT ON-SITE VISITS TO ASSURE BUSINESS IS BEING CONDUCTED IN A PROFESSIONAL MANNER. (3) CONTINUED AND EVEN STEPPED-UP MONITORING OF CE REPORTS OF VOLUME SOURCES AND I MIGHT ALSO ADD OF OTHER NON-VOLUME SOURCES' CE REPORTS. (4) INCREASED COORDINATION BETWEEN DDS'S TO ASSURE QUALITY REPORTS. WHILE THESE SAFEGUARDS WILL NOT RESOLVE ALL OF OUR PROBLEMS, HOPEFULLY THEY WILL ASSIST IN MINIMIZING THESE PROBLEMS.

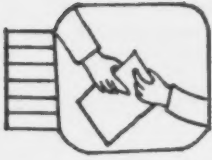
THANK YOU.

3/23/82

REGION I WORKS IN PROGRESS REPORT

1. Connecticut
 - A. VS-80 Wang Data processing word processing case control and fiscal data system. (Nebraska System) Contact Conn. DDS - Pete Corato or Nick Galotti.
 - B. Modular office furniture - about 60% increase in density of staff work stations with good privacy and sound control. contact Conn. DDS - Pete Corato, Administrator, Jerry Riopel - Project Coordinator.
2. Maine - same old real low processing time. (a closely guarded secret)
3. Massachusetts
 - A. Work simplification (as presented at Forum) Contact-Jerry Bruno
 - B. CE Process reorganization
 1. Ranking panel members and classifying them
 2. Block time scheduling
 3. Payment premium for reports received promptly
 4. Lab work before the exam in the patients home
 5. Sample quality review of exam reports.

Result - 22-24 day average time from order to report.
Contact - Fletcher Bishop or Refus Lawrence
4. New Hampshire
 - A. Moved Recon caseload to initial examiners. Contact - Russ Day
5. Rhode Island
 - A. Use Wang WP equipment to do case control. (Wang said it couldn't be done) Contact - John Pompei
6. Vermont
 - A. Training rotation of Senior Examiners to Q.A. unit for 3 months tours of duty.
 - B. Incentive pay for high volume producing examiners and clerical staff.
Contact - Ted Allen



WORK IN PROGRESS REGION II ON THE GO

NEW YORK

1. Guidelines were developed for evaluating/monitoring volume providers.
2. For periodic CDI's, reviews have been increased at the QA and supervisory level.
3. A post card is being mailed with the Due Process letter for acknowledgement of receipt.
4. Guides and orientation were developed for the examiner's use to deal with threatened suicide.
5. Meetings have been held in Psychiatric facilities to provide training in complete reporting on psychiatric evidence.

NEW JERSEY

1. A Satellite Office in Camden was opened to handle initial claims filed in southern regions of New Jersey. This amounts to twenty percent of all initial claims filed in New Jersey. The office is autonomous.
2. A special unit was organized to handle the initial development of periodic CDI's. The unit has been successful in easing the burden placed on the CDI examiner by the periodic CDI's.
3. Three adjudicators are outstationed at DO's to interview claimants and screen cases for first referrals for CE's. The goal of this program is to reduce processing time.

PUERTO RICO

1. An Informational Bulletin was prepared to be distributed to claimants through DO's. It includes orientation on CE's, treating sources and their impact on the final decision.
2. Reorganization of Medical Staff functions to take advantage of each doctor's expertise. Psychiatrists analyze medical evidence, grade severity and establish RFC's. Input given to psychiatric cases while being developed provides for assigning the case to MD's with other specialties for their signature on the final disposition of the claim.

3. Clerical personnel was provided to be responsible for clerical functions originally assigned to examiners (i.e. filling forms for requesting medical evidence, follow-ups, etc.). This new arrangement provides more time to the examiner for the technical work.
4. The training package has been modified by initiating the trainee in handling cases at the end of the second month of training.
5. A continuous revision of forms and procedures is being done to improve, simplify, eliminate, or consolidate information or actions in order to save time and effort. Major changes are tried in pilot projects before full implementation. This helps streamline difficulties or problems.

INFORMATIONAL BULLETIN

Very important aspects of your application for Social Security disability benefits are discussed below.

-- It is important to point out that the degree of severity of a condition is determined in accordance with Social Security Administration's regulations and not on the basis of opinions expressed by SSA physicians, consultative doctors, or your personal sources of treatment. If you are disabled or not according to the Social Security definition is not determined by these doctors.

-- The examining physician's responsibility is that of interviewing, examining the claimant, and making a written report on the findings.

-- The medical report is not the only evidence considered for determining incapacity. Other factors are taken into consideration and are equally important such as your work history, age and academic or vocational preparation.

-- It is of utmost importance that you attend to any medical appointment scheduled unless you have a justifiable reason for not doing so. If you can not attend the appointment, please call the Disability Determination Service collect (754-8989) and let us know your reason. If you do not give us a justifiable reason for not going to the appointment, your case may be decided with the evidence in file. If it is insufficient to determine the severity of your condition, you will not be eligible to receive benefits.

-- You should cooperate with the examining physician so that he will be able to perform a good evaluation of your condition. If there is someone accompanying you, the doctor will determine whether it is necessary to interview that person. However, usually the claimant is examined alone.

It is our hope that the information provided above will give you a clear understanding about the use and importance given to all the evidence in your file.

WORKS IN PROGRESS IN OUR DDS

REGION III

Presented at

DDS Management Forum Seminar

"Better Management Through Sharing"

El Paso, Texas

March 21-24, 1982

Rudolph W. Baker

REGION III - STATE AGENCIESDelaware

Disability Determination Services
820 W. French Street, 7th Floor
Wilmington, Delaware 19801
Phone: (302) 571-2871

Henry J. Matuszewski, Administrator

District of Columbia

Disability Determination Division
1411 "K" Street, N.W., 13th Floor
Washington, D.C. 20005
Phone: (202) 727-0492

Reid Rector, Division Chief

Maryland

Disability Determination Services
P. O. Box 17011
Baltimore, Maryland 21203
1232 E. Joppa Road
Towson, Maryland 21204
Phone: (301) 321-3824

Rudolph Baker, Administrator

Pennsylvania

Bureau of Disability Determinations
1310 N. Seventh Street
Harrisburg, Pennsylvania 17120
Phone: (717) 783-3620

John DelPaine, Director

Virginia

Disability Determination Services
4900 Fitzhugh Avenue
Richmond, Virginia 23230
Phone: (804) 257-0195

C. Roland Owens, Assistant Commissioner

West Virginia

Disability Determination Section
Heson Building, 2nd Floor
1206 Quarrier Street
Charleston, West Virginia 25301
Phone: (394) 348-3340

Anderson Allen, Director

ELECTRONIC DATA PROCESSINGDistrict of Columbia

The use of EDF is in the planning stage. Consideration is being given to jointly developing EDF with the Maryland State Agency.

Maryland

The data processing system currently has the capability for case control, automatic case assignment, and production of a punched paper tape with 8029 case receipt information. Plans are being made to further develop the system to include a clearance procedure, SACR report production, and other management information.

Pennsylvania

Automated Management Information System is planned for September 1982.

Virginia

A cost benefit analysis has been completed and programs are currently being written. Implementation dates:

Phase I - Case Control	- January 1983
Management Information	- January 1983
Phase II - Fiscal	- January 1984
Quality Assurance	- January 1984

WORD PROCESSINGMaryland

The DDS has developed a procedure by which personalized denial notices and technical rationales are prepared on word processing equipment.

Virginia

Recently updated word processing capability by installing IBM display writers.

Automation of CE operations - The word processor will be used to generate CE authorizations.

MEDICAL EVIDENCE OF RECORDDistrict of Columbia

Teletyping - A teletyping system is currently being used to obtain existing medical information.

DDS/Hospital Liaison - A DDS staff member hand carries Form 827 (Authorization to Release Medical Information to the Social Security Administration) to local hospitals and returns one week later to pick up information.

West Virginia

Specialty Group Recruitment and Monitoring - The DDS is establishing advisory groups of medical specialists. This process was used to recruit and train Psychologist Panelists. An Advisory Committee of Psychiatrists has agreed to develop a similar package for their specialty. Additional specialty groups will be scheduled at approximately three month intervals.

The State Agency has obtained a commitment from the President of the State Medical Association to help the agency meet its needs for medical information. A monthly series of articles on DDS medical information requirements is being published in the State Medical Association Journal.

PLANNINGMaryland

This State Agency has developed a planning model to identify and propose solutions to short term and long range objectives. The model uses an approach recommended by the American Management Association. The DDS model is designed to identify as completely as possible all agency needs and then to decide which needs are to be met.

ORGANIZATIONAL STRUCTUREMaryland

Fiscal Section Within the Consultative Examination Unit - The fiscal section will prepare authorizations for purchasing medical reports, review those reports and authorize payment. The unit will also process the authorizations to the parent agency, maintain bill paying information, handle medical evidence of record bills and transportation vouchers.

Routing/Assembly Unit - This unit will process personalized denial notices on the word processor, assemble completed cases and route the case to the proper destination, prepare residuals for counselors, process any VR referrals, and maintain records for reports.

Virginia

Specialized Determination Units - The DDS assigns examiners to adjudication units as follows:

Training Units
Intermediate Units
CDI Units

TRAININGDistrict of Columbia

Training (New Examiners) - Discussing the possibility of assigning new examiners to new examiner training programs conducted in the Maryland State Agency.

West Virginia

Correspondence course training material is being developed for physicians.

DDS/DO COMMUNICATIONSPennsylvania

The State Agency plans to make formal presentations in District Offices throughout the State.

West Virginia

This State Agency has expanded the procedure whereby DDS examiners call the Social Security field offices to request development when a non-insured status alert is received. The expanded procedure includes the following issues: work activity, whereabouts unknown, change of address, etc. The procedure was designed to reduce claims processing time.

WORKFLOWMaryland

This State Agency is currently open for compensatory time on Saturdays in order to eliminate a backlog of CDI claims. Adjudicators and clerical staff members carry out the initial screening and 434a preparation for all CDI claims received. Upon completion of this initial work, the claims are assigned to a regular adjudication section.

Virginia

Processing CDI Workload - Uses clerical staff and word processing to prepare 434a for all CDI claims as they are received in the State Agency.

PROGRAM EVALUATIONPennsylvania

A Developmental Skills Survey Program - An ongoing program to assess the developmental skills of adjudicators in order to provide appropriate training. Implementation date: Ongoing

Statewide Services Delivery Assessment - A survey of claimants is being conducted in order to assess the delivery of services. Implementation date: May 1982

STAFF APPRAISALDelaware

This State Agency is implementing an Employee Performance Evaluation System. This is a management by objective approach to planning. The Delaware system incorporates two basic features: First, an analysis of the job and what is to be done during the coming period; and second, an evaluation of how well the employee performed.

The Delaware System requires at least one formal interview at the end of the rating period. However, it is assumed that several informal interviews will occur during the rating period.

The Delaware System is designed to provide a significant boost to employee productivity because vertical communication has been enhanced. Employees will understand what they are supposed to do and they will receive on the spot coaching/counseling.

Pennsylvania

Civil Service - Merit promotional examinations - The development of standardized examinations for all supervisor and adjudicator promotions. Implementation date: Ongoing

WORKS IN PROGRESS

DDS's IN THE CHICAGO REGION

ILLINOIS

INDIANA

MICHIGAN

MINNESOTA

OHIO

WISCONSIN

IllinoisI. Quality Assurance Functions:

- A. The QA Unit will change to a 10% sample of all claims produced by the agency. The sample will be selected on a category basis and should provide a representative sample for each examiner over the period of a year.
- B. The major emphasis in special studies will be placed on auditing consultative exam sources. QA will coordinate closely with Section Chiefs regarding high volume source problems and ongoing communication with consultative sources to assure that a good consultative product is obtained.
- C. The Quality Assurance Unit's review of sample claims will be revised to concentrate on substantive issues. This will permit a quicker review on the increased number of claims anticipated. By concentrating on these issues, a better product will result. There will continue to be a strong emphasis on proper documentation and evaluation; however, the idea of reversibility will also be a major part of the Quality Assurance review.

II. Word Processing

A word processing pilot project designed to assess actual agency word processing needs is in progress. Appropriate forms are being formatted into the system. Several of the forms have been completed as a part of the clerical support for the adjudicative staff. An agency committee is reviewing the progress of the W/P pilot and developing additional applications for the system throughout the agency.

III. Review of Agency Position Classifications

In order to improve personnel participation on the adjudicative process at both the professional and clerical levels, the agency is reviewing selected job classifications to ascertain if established duties and functions truly meet the needs of the organization, especially since program responsibilities have grown as a result of the 1980 Amendments.

Thus far, a new para-professional position to assist the Quality Assurance Unit and Adjudicative Services Section has been established, the Training Unit's classification has been upgraded and the Vocational Supervisor classification has been rewritten. The unit and Section Chief position within the Division of Adjudication Services are being reviewed, and the establishment of a Disability Claims Analyst II position has been proposed.

IndianaI. Word Processing

Indiana has 34 word processing/data processing terminals, five printers, two central processing units, and two disk drives. Applications now operational include merged text generation of MER letters, case processing labels, merged text generation of denial letters, personalized attachments and technical rationales, automated claim vouchers and final payment, automated forms storage, and storage of DDS manuals. Automation of the general correspondence for the C/E process is close to implementation.

The ultimate goal is to combine data processing and word processing into a single text entry system using the data processing system originally developed for the Nebraska DDS.

II. Case Lift

Because the agency is located on four floors, a multi-floor case lift was installed. This allows an operator to send "tubs" of material to any floor and then return the lift to the originating floor.

III. Volume Medical Facilities

The following procedures are being implemented to monitor volume CE sources:

- A. Video tapes of the office facilities will be reviewed and approved by the DDS medical and administrative staff.
- B. A curriculum vitae for physicians and the type of examination to be performed must be approved by the Agency Chief Medical Officer before examination can be performed. Other staff used by volume medical vendors must have recognized credentials in their respective areas.
- C. A statement from the agency must be posted in the waiting room of the volume medical source inviting the claimant to discuss any problems regarding their examinations with the DDS medical coordinator.
- D. The purchase date and maintenance history of all major medical equipment must be posted near each machine.
- E. A minimum of two unannounced visits to volume facilities (by Agency personnel) will be made each year.
- F. The size of any one volume medical source will be limited to three locations within the State and one million in payments by the Disability Determination Division.
- G. The number of examinations scheduled will be limited to three per hour per physician, with a maximum of a ten hour day. Some variations in scheduling will be made to allow for no shows and claimants who are scheduled only for a specific test.
- H. A screening will be made of all reports when they are received in the agency. Inadequacies, contradictions or other problems with the report will be identified and communicated to the volume source. The agency will either reschedule the examination or adjust the bill as determined appropriate.

IndianaIII. Volume Medical Facilities (Continued)

- I. The examining physician must complete and sign the report, only after reviewing x-rays and laboratory findings.
- J. Special requirements for particular examinations will be furnished from the Social Security Administration.

MichiganI. Casework Job AidesA. Appointment Clerk Manual

This job aid is used by persons who schedule consultative examinations. It is designed to foster equitable vendor utilization and contains all agency policy and procedure in this area. The length is 325 pages.

B. Personalized Denial Notice Manual

A compilation of all relevant policies, POMS, clarifications and samples of PDNs is used in the writing of denial notices by disability examiners. The length is 70+ pages.

C. Continuing Disability Investigation Manual

This contains all policy and procedures (POMS and SSA Issuances) in one reference. The length is 100+ pages.

D. 831 Completion Manual

This manual is composed of POMS and other reference material which describes how the 831 should be completed. The manual covers both initial and reconsideration cases. It explains the how, when and why of 831 completion. The length is 250 pages.

E. Privacy Act Manual

This job aid contains all policy, procedure, POMS and copies of the letters used in processing FOIA requests. The length is 50 pages.

II. Special Medical Arrangements and Job AidesA. Early Appointment Procedure

Arrangements are made with selected Social Security District Offices to send the claimant to a consultative examination the same day the application is filed. D.O. claims representatives have a set of criteria and if a SSI applicant with no current sources meets these criteria the claimant is sent to a C/E the same day she/he applies.

B. Medical Brochure Series

Several brochures are used with attending physicians and hospitals in our public relations effort to communicate program documentation needs. Another series of brochures is used with C/E vendors and describe reporting requirements, billing procedures, documentation needs, etc. Brochures in both series cover the following body systems and examination types; musculoskeletal, psychiatric, neurological, ophthalmological, internal medicine, psychological and hospital records.

C. Vendor Discussion Guide Form

This two page NCR paper form is used when recruiting vendors for performing C/Es. It provides vendors with a clear understanding of our expectations relative to the performance of C/Es. The form is signed by the DDS person doing the recruiting and a copy is given to the vendor after each item has been reviewed verbally.

III. Quality Appraisal - Job AidesA. Quality Assurance Handbook

This will be revised in the near future. It contains all Michigan and SSA QA policies, procedures and forms with instructions for reports, special studies and citing deficiencies. The length is 120+ pages.

MichiganIII. Quality Appraisal - Job Aides (Continued)B. Special Studies Manual

This manual contains information on how to conduct, research and write a wide variety of studies. It also contains tables for use in determining sample sizes, instructions on flow charting and various research methods. The length is 200+ pages.

IV. Miscellaneous Job AidesA. Supervisors Manual

This is a comprehensive compilation of all policies, procedures and materials that supervisors must reference in performing management duties. Some of the topics covered are: Employee Performance Ratings, Progressive Discipline, Time and Attendance, Grievance Procedures, Emergency Procedures, Personnel Policies and Procedures, and Career Development. The length is 300+ pages.

B. DDS Accountability System Booklet

This booklet contains a description of the Michigan Performance Appraisal System, including copies of position descriptions and rating factors for over 10 jobs in the agency. The length is 100 pages.

C. Media Usage Survey

This nationwide survey of DDS's lists the kinds of audio-visual equipment and programs being used to meet training and public relations needs. It is designed to facilitate resource sharing between DDS's.

MinnesotaIdentifying and Reporting "Delay Time"

Delay time is time lapse that occurs when a disability examiner fails to take action on a claim as quickly as required by agency performance standards. The ideal is, of course, to have no delay time but this is seldom reached. This time is reported on a monthly basis by Quality Appraisal. An examiner who is reported as having significant amounts of delay time is obviously having trouble and this report is a good measure of the extent of this difficulty. It is particularly helpful with newer examiners.

Delay time is tracked by Quality Appraisal as a part of their regular sample case review. It provides an accurate and objective measure of an important aspect of examiner performance and can therefore be given considerable weight by supervisors in examiner evaluations.

Although this is a negative measure it is a necessary one. Its objectivity does provide firm support when discipline based on poor performance is necessary.

OhioI. Monitoring Consultative Examination Services

Ohio has monitored its consultative examination sources for years and has had no major problems related to them. Recently, however, the questions being raised nationally, regarding volume sources along with the increased number of complaints that accompanied the influx of CDI's caused a reevaluation of the adequacy of the system being used. It was readily apparent that although methods in use provided adequate control for operational purposes, they failed to achieve the level of credibility needed to demonstrate the soundness of the system to those outside the agency. For this reason, a monitoring system is now being set up which will demonstrate objective evaluation of facilities and fully document the performance of consultative sources on an ongoing basis.

All volume sources are to be visited at least once each quarter (announced and unannounced). During these visits, the entire C/E arrangement between the facility and the DDS is to be reviewed and evaluated, the physical facility is to be inspected and randomly selected clients are to be interviewed on sight after examination. Lower volume sources are to be visited on a less frequent basis, but all but the very low volume sources will have at least one on site contact a year. In addition, an ongoing system involving phone contact with randomly selected clients shortly after examination to obtain their reactions to the examinations will be used to identify possible problems. Documentation of each step in the process maintained by facility will not only permit quick identification and correction of problems, but also demonstrate to those not familiar with the process that proper control is being maintained.

II. Word Processing

The Ohio DDS is in the process of modernizing its word processing system. Plans are to use the Wang VS system and merge it with the existing data processing base. This, combined with minor additions to the current data base will eliminate the large amount of duplicative support efforts that are now necessary and will result in substantial cost savings over a brief period.

These changes will permit interface with the SSA case control system and the large central memory capacity of the VS system will provide the following advantages:

1. Sharing of common information by various departments of the agency thereby eliminating considerable duplicate keying. This includes sharing between Columbus and Cincinnati Offices.
2. Access by all sections of the agency to case control information for better response to the public.
3. Automated control of C/E appointments and follow up with access to this information by operating units.
4. Automated methods of maintaining manuals
5. Terminal to terminal communication between offices.
6. Vastly improved management control systems.

WisconsinI. Reorganization of The DDS

This was initiated a little more than a year ago in order to accommodate the considerable increase in staff which was projected to enable the agency to handle the large increase in CDI's. The reorganization was designed to move Wisconsin from the configuration of a relatively small state to that of some of the larger states. It introduces an intermediate level of management that will supervise first-line supervisors and thereby provide the Director and Assistant Director the time needed to plan and handle other significant administrative matters.

II. In-House, On-Line EDP System

Although perhaps not as important to the organization, but certainly more significant from the standpoint of accomplishing more work and improving productivity is the effort to establish a completely in-house, on-line EDP system. The Wisconsin DDS has been served by an EDP system for more than 10 years, but there is not a direct hookup and data entry into the system has been by means of paperflow and keypunch operations. This has made for a rather inefficient system in that data has to be keyed twice and in-house case control is based on the paper filing system. The new thrust is to eliminate dependence on a centralized department computer in favor of mini-computers which would be located on the premises of the DDS and under its control. Access to case control information would be direct on a real time basis. Case control data would be keyed only once and then would be part of the computer record. Management reports would ultimately be produced locally. Control of the flow of work within the agency would be by means of penlight scanning devices which would give the computer the capability of providing the location of any case in the agency on a real time basis. Planning for this is based on the system currently operating in the Tennessee DDS. The introduction of such a system is seen as a way to dramatically increase productivity and reduce considerably the need for further expansion of personnel.

Ultimately, instructional manuals and other similar printed material can be added to the computer memory, and a complete word processing function can update and reissue such manuals with a tremendous time savings both for the training staff which is involved in writing in-house manuals, and for the adjudicator and clerical staff which has to take the time to file the manuals.

III. Additional Space

The Wisconsin DDS is working on trying to find additional space. Already a satellite office located several blocks from the main headquarters has become necessary and there is insufficient room for expansion in the main headquarters to add the staff recently projected for the increase in CDI's for Fiscal Years 1983 and 1984. The DDS is at a crossroads in terms of how it will expand. Up to this point, the DDS has approximately doubled in size in the last nine years but all in one location. The move to a satellite office this past fall was necessitated by a lack of space rather than any specific plan. However, with the projected staff increases for the coming year, the DDS will probably go beyond 260 staff and believes that it must make a decision now as to whether it will begin opening branch offices. The matter is under review with the major issues being

WisconsinIII. Additional Space (Continued)

whether or not there is sufficient planning time to go to branch offices before the increase in staff has to be absorbed. It is not certain that there is such time, but it is also recognized that a decision not made now could delay expansion to a branch by several years. There are considerable reservations about trying to locate a staff of 260 or more in one location, and further handicapped by the fact that being located in a relatively small city, there are not that many locations which could efficiently house an agency of that size.

WORKS IN PROGRESS IN REGION IV

The Atlanta region consists of eight states, Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. There are nine separate DDS's in the region with South Carolina having the primary DDS under the Department of Vocational Rehabilitation and a separate and independent unit under the Commission for the Blind. The DDS's in the region have been progressive in their outlook and are consistently looking toward innovative techniques to improve the claim process. The following brief summaries represent some of the activities that are underway at this time.

I. Alabama

The Alabama Agency is currently in the process of implementing a multifunction data processing and word processing system to improve their handling of many agency functions. The system, utilizing a Four Phase Computer, will handle case control, fiscal reporting, and management reporting under the data processing activities. Under the word processing functions, the system will generate medical evidence of record requests including an automated follow-up request system when no reply is received. The system will generate consultative examination authorizations and correspondence, and will also include follow-up diary and request generation. The Alabama Agency has been vigorously pursuing the implementation of this system, and has a programmer on the staff who is presently undergoing training in the disability operation. This resource will be valuable in helping the state maintain the system in an up-to-date fashion.

II. Florida

Florida, beside being one of the larger states in the region, was the first state in Region IV to be decentralized. The state has five operating units with the central office being in Tallahassee. The state has been innovative in many areas and has established a record of high quality and efficiency. The state is deeply involved in word processing and has established an effective system for minimizing extraneous material while maximizing the effectiveness of correspondence to claimants and medical sources. Florida uses a combination of Lanier and IBM word processing equipment and is continuing to explore other avenues to improve data processing and word processing. They have experimented with the use of the equipment for personalized denial notices, but found the major benefit to be in generating technical rationales. In addition to the word processing equipment, Florida uses an effective centralized dictation system for communicating with the word processing units.

Although having a noteworthy reputation in case processing, the state of Florida has also been extensively involved in the development of performance standards and job descriptions for its staff. A current system that has been of substantial benefit to the state is a uniform set of criteria for making equitable promotions of Disability Examiners. The system utilizes a set of criteria based on performance, previous performance appraisals, Supervisor's recommendations, years in service, and an interview with a full description of how each one of the criteria is to be evaluated and the weight each component will have in the ultimate decision. The system has gained the support not only of the staff but also the union, and has increased the equity in staff promotions.

III. Georgia

The Georgia State Agency has also been extensively involved in word processing and utilizes a combination of IBM System 6 equipment and a unique application of IBM electronic typewriters. Utilizing the IBM Model 75 equipment, the state has been able to create texts for personalized notices from certain programmed information combined with Examiner generated narrative, and has produced high quality notices. This use of equipment not generally felt to be capable of extensive word processing functions is a creative approach to some of our workload problems. Georgia has also been involved in the piloting of the person-to-person interview at the recon level (DARE Project) and has represented the states well in this effort. Although there are many areas of the agency's operation that are very effective, there are two more routine functions that Georgia has handled in a noteworthy fashion. The handling of supplies in the agency has been made highly efficient by utilizing a specialist in supply and equipment handling and operating from a central supply point. This system insures ready availability of equipment and supplies needed, as well as high accountability in expenditures and inventory. The agency also has installed a highly efficient electronic telephone system that has increased staff efficiency noticeably.

IV. Kentucky

The Kentucky Agency has also become highly experienced in word processing, particularly in view of the tremendous increases in workload coupled with severe staff limitations. The agency uses CPT equipment and has combined the use of the equipment with careful attention to "form" design. By increasing the efficiency of their word processing equipment and minimizing the individual actions necessary when preparing documents, the agency has managed to continue an efficient operation even in the face of severe staffing problems. Modifications to their correspondence in the CE process have been particularly effective.

V. Mississippi

The Mississippi Agency was one of the pioneers in the region in word processing and has established a reputation for effective use of this type of equipment. Currently the agency is utilizing IBM System 6 equipment and centralized dictation to carry out an effective typing process. They are also currently involved in the development of a computerized case control system, and although Four Phase Equipment has been fully evaluated, the agency is still considering other vendors before proceeding with their plan. All documentation and feasibility studies have been completed and equipment acquisition should begin in the near future.

Mississippi has also had an exceptional record in processing time and aged cases. Much of this success is due to innovative and imaginative action by DDS management in the area of staff development and case flow. The agency has established a highly successful system involving the use of telephone development through the claimant in an early stage of the claim process. These contacts are directed toward rounding out the information obtained on the 3368.

The administration in Mississippi has long recognized a need for a comprehensive staff development program. As a result they have used outside resources to provide Examiners with specialty training in areas such as stress management, as well as areas more directly involved with case production, such as time management.

VI. North Carolina

The North Carolina Agency has utilized an extensive central dictation and word processing center since the early 1970's. In combination with IBM System 6 and other electronic typing equipment, the agency uses a multiple centralized dictating system to bring correspondence to the word processing center. Their process is always undergoing evaluation and improvement. The agency also uses access to the parent agency's computerized finance system to process payment for consultative examinations and evidence of record. This system allows for greater accountability in obligations reporting.

One of North Carolina's chief strengths has been in the area of staff development and training. One of the unique approaches that the agency has taken is the training of Medical Consultants utilizing all or parts of the Examiner training material. This approach insures better physician awareness of the program requirements and enables them to better focus their review when certain technical issues are involved in a case.

VII. South Carolina

The South Carolina Agency, although not as heavily involved in the development of word processing systems as other states in the region, is utilizing IBM System 6 equipment on a limited basis, primarily for the purposes of evaluation. The state has a computerized case control system that provides extensive management reporting and case processing information including quality assurance and fiscal data. The computer system has been in use since 1976 and has proved extremely effective for handling reporting and caseload monitoring. The agency is currently evaluating not only the use of word processing equipment as an independent function, but ways of interfacing data processing with word processing functions.

The agency has developed a unique and effective office policy and instruction manual that provides the staff comprehensive instructions on the implementation of program requirements in the state of South Carolina. This manual consists of a series of memoranda that directly parallels the PQMS instructions with each memorandum numbered in accordance with the section of PQMS that it is addressing. The manual is also sufficiently comprehensive to use for training of new staff members, particularly clerical staff, and is extremely comprehensive regarding the agency's operations.

The agency has also utilized a physician for much of its professional relations (medical relations) activity. This has established a higher degree of credibility among the members of the medical community and has provided an optimum point of contact for physicians wishing to inquire about the program. The agency is decentralized with three operating units and a separate administrative office. The Quality Assurance Unit is located in the Central Office with reviews being done centrally.

VIII. Tennessee

In July, 1981, the Tennessee Agency implemented a computerized case control and word processing system. The system uses the Four Phase equipment with a wide range of terminals and printers. The system is currently being developed to produce all management information reports, including the SAOR, and is also being developed for producing correspondence. At the present time, the system is performing some

fiscal functions and an expansion of this application is being planned. Tennessee is working jointly with Alabama and Mississippi to develop the necessary capabilities for computer generation of ARS input.

IX. The Region At Large

The DDS's in the Atlanta Region have worked closely with the Regional Office to improve the operation of the Disability Program. Two items that may be of interest to other regions are the Regional Medical Council and the DDS Administrator "Break-Outs" at the periodic Administrators' Meetings.

At the regularly scheduled DDS Administrators' meeting, the Administrators have been meeting separately for the purpose of a candid discussion of issues facing the DDS and the development of possible solutions for approaches to problems that arise. Although the format of these meetings is still evolving, so far they have been productive both to the Administrators and the Regional Office. Summaries of issues and suggestions have been provided to the DFB Director for his response or review.

The Atlanta Region also has had a Regional Medical Council for quite some time with each DDS in the region having a physician representative on the Council. At the periodic meetings of the Council, medical issues of concern are discussed and possible approaches to solving problems in medical evaluation are formulated. At least one DDS Administrator represents the DDS's and the meeting also includes representatives from the Office of Assessment, as well as DPB. The Council is chaired by the Regional Chief Medical Consultant and formal reports of the council's actions are prepared for DDS Administrators.

DDS MANAGEMENT FORUM

EL PASO, TEXAS

MARCH 23-24, 1982

AN ANALYSIS OF ADMINISTRATIVE,
PUBLIC RELATIONS AND SPECIAL
PROJECTS AND STUDIES
OF THE DALLAS REGION

RAYMOND NANCE

PROGRAMS COORDINATOR

OKLAHOMA DDS

ADMINISTRATIVE PROJECTS

1. Reorganization of office into 4 areas of responsibility:
Initial and Recon Operations, CDI Operations, Program Analysis
and Fiscal Management - each managed by a coordinator.
(OKLAHOMA)
2. Assignment of CDI caseloads on a geographic basis that corresponds
to the initial module distribution so that small CDI caseloads may
be assigned to initial examiners more effectively. (OKLAHOMA)
3. Use of a telerecorder system. (OKLAHOMA and LOUISIANA)
4. Use of a transcription service to type telerecorded MER's and
CE's. (OKLAHOMA)
5. Establishing minimum level of satisfactory job performance for
each job title in Agency based on processing time and accuracy.
(NEW MEXICO)
6. Monthly award for best accuracy rating for secretary and examiner
given by Quality Assurance and Administration and monthly award for
highest number of case clearances given by Operations Supervisor and
Administration. (NEW MEXICO)
7. Provide cash awards to outstanding employees. (NEW MEXICO)
8. Use of word processor for case control, personalized notices and
correspondence. (OKLAHOMA and TEXAS)

9. Development of a POMS Index which is also cross-referenced to in-house Administrative Policy Manual. (TEXAS)
10. Development of word processing manual for disability examiners to aid in their requests for correspondence and personalized notices. (TEXAS)
11. Development of a medical transcription training package for clerical who type telerecorded reports. (LOUISIANA)
12. Use of an abstractor stationed in local hospitals to process DDS requests. (LOUISIANA)
13. Development and maintenance of guidelines for medical development practices within DDS. (OKLAHOMA)

PUBLIC RELATIONS PROJECTS

1. Development of a booklet describing the role, organization, achievements and goals of the DDS. (TEXAS)
2. Visits with DO's, Area Director and ALJ's to discuss problems. (Arkansas)
3. Survey of psychiatrists, psychologists and pediatricians to determine what kind of testing they can do and the minimum age level they can test. (ARKANSAS)

4. Keep a list of doctors who refuse to answer requests. (LOUISIANA)
In addition to those who refuse to cooperate, we also keep a list of any source who requires a special development procedure in order to provide evidence. (OKLAHOMA)
5. Development of a ½ day workshop for CE panelists on the disability program. (OKLAHOMA)
6. Development of medical examination guidelines packet for new CE panelists. (OKLAHOMA)

SPECIAL PROJECTS AND STUDIES

1. Examiner out-stationed in DO to develop and adjudicate claims in that service area. (NEW MEXICO and ARKANSAS)
2. DO initiation of medical evidence of record in initial claims.
(NEW MEXICO and OKLAHOMA)
El Paso DO initiation of CE's on selected claims. (TEXAS)
3. Copying and holding in DDS of initial and Recon diaried cases so that CDI can be conducted timely in DDS when diary matures. (NEW MEXICO)
4. QA Study of quality and timeliness of work performed in secretarial units. (NEW MEXICO)
5. Conducting CDI's on all recipients in current pay status due to Drug Addiction and Alcoholism (DA & A) criteria. (TEXAS)

6. Cooperative effort with RO and local industry to investigate job opportunities for claimants in Dallas County. (TEXAS)
7. Studies to evaluate word processing equipment and dictation and transcribing systems to determine which equipment is most suitable. (TEXAS)
8. Elapsed Time Study. (TEXAS)
9. Study to determine most efficient method of handling proffering vouchers. (TEXAS)
10. Feasibility study on use of microfilms for storage of proffering letters. (TEXAS)

REGION VIIKANSAS

1. Implementation of data processing and word processing
2. Using Q.A. examiners to assist line unit examiners in caseload management

MISSOURI

1. Concerns for the continuing incompatibility by the DDS denials and cessations and ALJ reversals
2. Need for national standardization of RFC

NEBRASKA

1. Realization of periodic review workload
2. Adverse public reaction to SSA adjudicative policy
3. More definite policies in the handling of psychiatric cases

IOWA

1. Continuing disability Q.A. review of cessations prior to release of Due Process letter
2. Review of high risk continuances (musculoskeletal, cardiovascular, psychiatric)
3. Volume Vendors
4. Budget and staffing related to the uncertainty of the CDI workload
5. We are proposing a study of whether word processing can be cost effective or can improve our processing time.
6. We have had Crisis Intervention Training to help our staff deal with hostile, angry claimants.
7. We have future plans for closer monitoring of CE processes.
8. Acquisition of data processing

WORKS IN PROGRESS IN DENVER REGION VIII

Colorado DDS	Anthony Francavilla	Administrator
Montana DDS	William Vollmer	Administrator
North Dakota DDS	John G. Locken	Administrator
South Dakota DDS	James L. Lefler	Administrator
Utah DDS	Charles E. Schmitt	Administrator
Wyoming DDS	Marie A. Clark	Administrator

1. The DDS Administrators have recently organized an informal Regional Administrators Council electing one of the administrators as chairman. This Council meets each quarter prior to the Quarterly Regional Office Administrator's Meeting to share information, communications and problems in operating state programs.
2. The DDS Administrators in this region as part of the Council activities are utilizing a monthly conference call to assist in dealing with common concerns and generally improved communications among the State Administrators.
3. The State programs have been participating in conference calls with the Regional Office staff, utilizing special conference telephone equipment allowing a number of people to be involved in each location.
4. With the cooperation of the Regional Office and their medical staff DDS physicians have been able to spend a day visiting the Regional Office and talking to physicians in the Disability Analysis Branch as well as other staff.
5. The Denver Regional Office is assisting the State Administrators in arranging to bring an expert into the area to provide a workshop on Crisis Intervention. This workshop will be held in each state with the states sharing the expenses of the expert.
6. The Utah DDS is proud to have one of it's state medical consultants featured in a national brochure, "Physicians, Your Skills are Needed", which is now being distributed throughout the country. The neurosurgeon featured in this publication is well known and respected both nationally and locally.
7. The Utah DDS with the assistance of the Regional Office is now attempting to resolve security problems identified with an audit and resulting from inadequate or insecure space. With the help of the Regional Office the Utah Parent Agency is recognizing the need for secure space that will result in a move to a different location.
8. The DDS Programs in Utah and Montana are utilizing a physician for consultative examinations who is willing to make house calls. This physician is a qualified psychiatrist and his cooperation is very helpful with the clients needing this type of evaluation.

WORKS IN PROGRESS IN DENVER REGION VIII

Page-Two

9. The Utah DDS has been and will continue inviting ALJ's in the Salt Lake Office of Hearings and Appeals to meet with DDS when medical training is provided for examiners. The Administrative Law Judges find this training helpful and the exchange with DDS staff beneficial to both programs.
10. The Montana DDS has developed a procedure for typing claimant reminder letters at the same time C/E appointments are typed. These letters are then dialed to four days before the appointment at which time they are sent to the claimants.
11. The Montana DDS is now writing a specific date in their close-out letters rather than noting the claimant will be given 10 days or 15 days, etc. from the receipt of the letter.
12. The Montana DDS reports they are using more NCR paper in much of their typing saving copy expenses and time.
13. A number of the State DDS's in the Denver Region have, or are now obtaining word processing equipment. Those states with similar equipment (IBM Displaywriters) are sharing some of the software development.
14. The North Dakota DDS and South Dakota DDS report they have eliminated the use of Dictaphones and now use a determination worksheet requiring very little writing. This process seems to reduce examiner to clerical turn-around-time by three or four days.
15. The Colorado DDS has recently been given approval by SSA to purchase an EDP system after doing a good job in evaluating the need for such a system. The Agency is now in the process of obtaining the EDP system.
16. The Colorado DDS has recently hired a statistical analyst to work in the program. This person has a Ph.D. and is well qualified in this specialized area to assist the Administration in special studies, etc.
17. Recently the Seattle Regional Administrators invited representatives from the Denver and Seattle region to attend their last Quarterly Administrator's Meeting. This exchange between regions seems to be a responsible and feasible way of communicating between regions with common interests in the western part of the country.

REGION IX DDS ACTIVITIESARIZONA

1. Planning to conduct a feasibility study for automated data processing as a fiscal year proposal.
2. Working on a policies and procedures manual to convey all non-POMS policies and procedures for total staff usage. The project was initiated last summer with the hope of its completion by this spring. Completion and implementation of portion on clerical procedures has brought about more uniformity of action throughout the agency. Other areas to be included in the total format are uniform procedures for QA staff, the medical staff, systems functions and an administrative section.
3. The agency, which is in Phoenix, recently opened a branch in Tucson and finds that this decentralization much more effectively serves claimant needs.
4. The agency has been reaching out to various state entities from whom it has been receiving calls relative to the CDI initiatives and cessations. Its outreach efforts include publications in various medical journals. A letter which explains the CDI process is included in each CE request for the doctor to read.

For more information on the above, please write or contact:

William R. Sims, Program Manager

Telephone: (602) 264-2644

CALIFORNIA

1. Conducting workload studies for analysts, clerical and M.D. staff. Currently evaluating their effectiveness.
2. Implementing word processing to include personalized denial letters, CE process, plus the entire clerical process to increase total efficiency. Word processing has resulted in eliminating the need to fill 115 clerical positions.
3. Experimenting with various-sized units. Calls for placing the highest producers in one unit and smaller producers in smaller units to provide more individualized assistance. Project was started 2 to 3 months ago so it is too early to measure its effectiveness.

For more information on the above, please write or contact:

Gary Adams, Deputy Director

Telephone: (916) 445-0800

NEVADA

1. For the last 6 months has been working on a multiphasic organizational development program. This consists of evaluation of management practices, redesigning of fiscal practices, development of informational systems, etc.
2. Is into Talent Pools, a kind of quality circle. Has several pools going. Talent Pools are felt to be very suitable for DDS's because it can be confined within the agency. It does not require parent agency participation.

For more information on the above, please write or contact:

Dan Mooney, Chief

Telephone: (702) 885-4430

HAWAII

1. Held a group discussion with agency psychiatric review physician on how to handle/sort out one's feelings about claimants who threaten to commit suicide/inflct bodily harm on us because of denial or cessation action taken on their claims.
2. Listened to a presentation on the Quality Circle by parent agency staff specialist. Hawaii DDS is deferring any action on Quality Circle adoption until more data can be gathered from the Vocational Rehabilitation sector which has started a quality circle on the clerical level.
3. Tried out two new claims procedures because of severe staff problems:
 - a) CDI packet mailouts were transferred from the line units to the Case Control Unit (intake), freeing the line unit clerical staff to do other more pressing work. This has worked out satisfactorily.
 - b) Shifted initiation of medical documentation of all initial claims to the QA Unit. This procedure deteriorated somewhat because some of the analysts felt that documentation requests were not being done to their satisfaction and preferred to initiate documentation on their own. The above procedure was instituted in view of critical staffing problems on the analysts' level.

For more information on the above, please write or contact:

Mrs. Mary Horie, Administrator

Telephone: (808) 944-8755

"WORKS IN PROGRESS IN OUR DDS"

REGION X

Alaska, Idaho, Oregon, Washington

ALASKA: Ken Hardy

- I. C.E.'s in the Alaskan Bush or transporting and providing room and board in a state with 4 time zones, 465,000 people and 586,000 square miles.
 - a. In getting people out of the bush for C.E.'s it sometimes involves a bush pilot being chartered, then connecting with major airline from smaller cities to Anchorage or Fairbanks, then being picked up by escort for helping them with language and the ways of the big city.
 - b. This can all lead to bad weather, aborted flights, iced jammed rivers and tremendous amount of coordination with vendors, airlines, motels, etc.
 - c. Costs of up to \$2,000 per C.E.

IDAHO: Stan Kress

- I. Quality Assurance: Finding what's right rather than what's wrong, or people who feel good about themselves produce good results.
 - a. We try to catch them doing something right and let everyone know about it and learn from it.
 - b. When trivial mistakes are made they are corrected rather than written up.
 - c. When major errors are found, 'training discussions' are held.

II. Word Processing.

- a. We are investigating and could use your help.
- b. Send your information of value to Idaho DDS, P. O. Box 4188, Boise, Idaho 83704.

OREGON: Tim Latta

- I. Q. A.: Indepth review reduced to 50% of time. 1 Q.A. reviewer per unit. They rotate units each quarter.

OREGON (Continued)

- a. In conjunction with Unit Supervisor the Q.A. reviewer negotiates what they will be looking for and what they want to know about the unit during the upcoming quarter.
 - b. One-half of the Q. A. time spent is agreed area.
 - c. The study could be end of line info or middle or beginning or the reviewer could be out involved in unit itself. (Each situation is unique.)
- II. Medical Courier - Portable copy equipment taken to 8 facilities to speed receipt of M.E.R.'s.
- a. Examiner Aid Position (between clerical and examiner on career ladder).
 - b. Goes to facilities within 1 to 1½ hour drive of DDS. Takes portable Canon 200 Photocopier, which is mounted on a mortician's gurney and can slide easily in and out of a station wagon.
 - c. Takes copier into building, gets info and back out.
 - d. Gets and sends info from the V. A. to State of Washington since Washington V. A. Hospital is near the Oregon DDS.
 - e. Copier should use dry toner - to eliminate spills and be easily unjammed.
- III. Quickie C.E. Process.
- a. Claimants who have phones are scheduled exams as soon as possible, within one or two days if possible..
 - b. Examiner calls and informs them of appointment. Reduces no shows.
 - c. Cuts up to two weeks off processing time.

WASHINGTON: Ed Davis

- I. Hosting Regional NADE Conference May 21, 1982.
- a. Dr. Bruce of University of Washington will speak on the Bruce protocol for treadmill testing.
- II. Opened branch office in Spokane.
- a. Covers Eastern Washington (25% of the state).
 - b. Better service and resolves space problems created by increased staffing.
- III. Conversion to an automated data and word processing system in January.
- a. Use of Nebraska software package and Wang hardware.
 - b. Replaces control cards and manually prepared SAOR.
 - c. Provides word processing to replace and/or assist typewriters and ball point pens.

WASHINGTON (Continued)

IV. Quality Circle program is in formative stages.

- a. A facilitator has been chosen and training and organizational needs are being investigated.
- b. Similar program, used 5 years ago, provided many solutions for work problems.

REGION X:

- I. All the states in Region X have initiated training on completion of the SSA-3368 and the disability evaluation process to C.R.'s in the D.O.'s
 - a. Use of SSA video tape on completing the 3368 for mental impairments.
 - b. Sessions include sequential evaluation, medical source requirements, release forms and question and answer sessions.
 - c. Enthusiastic response from both D.O. and DDS staffs.

MAR 23 1982

GRENNAN, FAULKNER & KOENIG

ATTORNEYS AND COUNSELORS AT LAW

2000 CLASSEN BLVD.

SUITE 120 SOUTH

OKLAHOMA CITY, OKLAHOMA 73108

TELEPHONE 525-8608

March 9, 1982

JIM GRENNAN
N. CLYDE FAULKNER
CARL KOENIG

TO SUBCOMMITTEE

COMMITTEE ON

MAR 22 1982

COMMITTEE ON WAYS AND MEANS

MAR 23 1982

WAYS AND MEANS

John J. Salmon, Chief Counsel
Committee on Ways & Means
U. S. House of Representatives
1102 Longworth House Office Bldg.
Washington, D. C. 20515RE: Hearings on Possible Irregularities
in Medical Examinations to be Con-
ducted by The Honorable J. J. Pickle
and The Honorable Charles B. Rangel

Dear Mr. Salmon:

I understand that, on March 11, 1982, hearings will continue on subject matter, and that the record will remain until March 19 to receive any written statements.

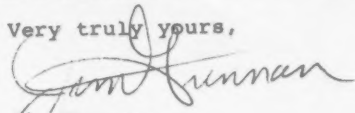
As a case study as to the quality of the state agencies' use of consultative medical examinations, I present to you the attached documentation on Martha M. Goodnight. Mrs. Goodnight is 60 years of age, born 10-16-21, and has received Social Security disability benefits since 1978. She was notified by the enclosed letter of December 21, 1981, from the State Disability Unit, of the requirement for her to keep three consultative medical examinations. Following those examinations, she received the enclosed letter of January 22, 1982, from Dr. Fiegel. I was employed by Mrs. Goodnight and reviewed her Social Security file and the consultative medical examinations. My review and advice to Dr. Fiegel is set forth in my letter to him of February 23, 1982, and received the enclosed reply from him of February 26, 1982. Contrary to the reports of the consultative examiners, which I enclose, Dr. Fiegel in his letter of February 26, 1982, opines that a neurological examination with an EEG is not thought to be justified in this case.

Therefore, based upon the enclosed, Mrs. Goodnight's period of disability which began in 1968 will be terminated and the administrative process of reconsideration by the Social Security Administration of the cessation of benefits will commence.

John J. Salmon, Chief Counsel
Committee on Ways & Means
March 9, 1982
Page Two

From my representation of Social Security disability claimants, I feel that the enclosed is but one storybook picture of cessation of benefits unsubstantiated by consultive medical examinations, and trust that it will shed some light upon the hearings being conducted by Representatives Pickle and Rangel.

Very truly yours,



Jim Grennan

cc: N.O.S.S.C.R.

JG:klb



STATE OF OKLAHOMA
OKLAHOMA COMMISSION FOR HUMAN SERVICES

DEPARTMENT OF HUMAN SERVICES
(Department of Public Welfare)

L. E. RADER
Director of Human Services
Mailing Address: P. O. Box 25352

Sequoyah Memorial Office Building
OKLAHOMA CITY, OKLAHOMA 73125
December 21, 1981

In Reply—Address to Director
Attention: Disability Insurance Unit

Ms. Martha M. Goodnight
6317 South Robinson Drive
Oklahoma City, Oklahoma 73139

A/N 440-32-1702

Your claim for disability benefits has been sent to this office for evaluation.

After review of your claim, we find that a special medical examination is needed. You are to be examined at our expense. The doctor will not recommend treatment, arrange for hospitalization or make the final decision regarding the extent of your disability. An appointment has been made with:

Richard B. Dawson, M.D.
1117 North Shartel
Hexagon Center, Suite 402
Oklahoma City, Oklahoma 73103

Date: December 30, 1981

Time: 9:00 A.M.

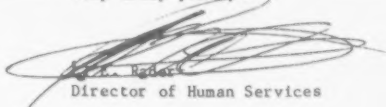
Telephone: (405) 235-4421

YOUR FAILURE TO KEEP THIS APPOINTMENT OR TO NOTIFY US WITHIN 3 DAYS PRIOR TO THE EXAMINATION DATE OF GOOD REASON WHY THE APPOINTMENT WILL NOT BE KEPT WILL MAKE IT NECESSARY FOR US TO MAKE A DECISION BASED ON THE EVIDENCE ALREADY CONTAINED IN YOUR FILE. ANOTHER APPOINTMENT WILL NOT BE SCHEDULED UNLESS WE ARE PROMPTLY NOTIFIED OF GOOD CAUSE FOR NOT KEEPING THIS APPOINTMENT.

Assistance in providing transportation can be obtained by contacting your local County Welfare Office before the appointment date. IMPORTANT: IF YOU WEAR GLASSES OR A HEARING AID, PLEASE TAKE THEM WITH YOU WHEN YOU GO FOR THIS APPOINTMENT. IF YOU ARE TAKING ANY MEDICATIONS, PLEASE TAKE THEM WITH YOU IN THEIR ORIGINAL CONTAINERS.

Please complete and return the enclosed form immediately in the envelope provided. Thank you for your cooperation and if you cannot go the examination, or have any questions concerning your appointment, please call extension 314 at (405) 525-3366.

Very truly yours,


L. E. Rader
Director of Human Services

Enclosures (2)
Acknowledgement

Okl. DHS Revised 9-81

DI-S-1

GOODNIGHT, Martha M.
A/N: 440-32-1702
Page 2.

Shreekumar S. Vinekar, M.D.
Okla. City Neuro-Psychiatric Clinic
437-Pasteur Medical Building
1111 North Lee
Okla. City, Okla. 73103

October 27, 1981 at 1:00 P.M.

Telephone: (405) 232-9895

This appointment is for a Psychiatric Examination.

This examination will take most of the day to complete.

Do not bring small children. If you cannot read or write, please bring an adult with you.

M. Thomas Duxton, Jr., M.D.
Shartel Professional Building
1117 N. Shartel, Suite 300
Okla. City, Okla. 73103

November 13, 1981 at 2:45 P.M.

Telephone: (405) 235-5534

Bring only one person with you to this examination.

Do not bring small children to the appointment.



STATE OF OKLAHOMA
OKLAHOMA COMMISSION FOR HUMAN SERVICES

DEPARTMENT OF HUMAN SERVICES
(Department of Public Welfare)

I. E. EIDER
Director of Human Services

Mailing Address: P. O. Box 25352

Squoyah Memorial Office Building
OKLAHOMA CITY, OKLAHOMA - 73125

January 22, 1982

In Reply--Address to Director
Attention: **Disability
Insurance Unit**

A/W 440-32-1752

Mrs. Martha H. Goodnight
6317 South Robinson Drive
Oklahoma City, Okla. 73139

Dear Ms. Goodnight:

Earlier, we told you we were assisting the Social Security Administration in determining whether you remain eligible to receive monthly disability benefits. To be eligible for such benefits, you must be unable to engage in any substantial gainful activity because of your impairment.

On behalf of the Social Security Administration, this is to notify you that based on evidence now in file it appears that a determination would have to be made that you had the ability to engage in substantial gainful activity in December, 1981.

You were originally found to be disabled because of a back condition and a nervous condition. You state that you continue to be unable to return to work because of these condition, dizziness and headaches. The evidence in file including special examinations and tests shows that you have the capacity to do a wide range of heavy, medium, light and sedentary work as long as it is not around moving machinery or at unprotected heights. It is felt you can still adjust to work activity within this range. You have good movement of your neck and extremities and your nervousness does not significantly interfere with your ability to work.

We are writing at this time to give you the opportunity, if you feel that you are still unable to work because of your impairment, to present any additional statement or evidence you want to be considered before a determination is made. If you want to submit such a statement or evidence, please send it to us within the next 10 days, using the enclosed envelope which requires no postage.

If you do not write us within 10 days, we will forward your records to the Social Security Administration where a formal determination will be made regarding your continuing entitlement to benefits. It is important, therefore, that you let us know within 10 days if you want to submit a statement or evidence even though you may need more time to submit it.

Okla. DHS Issued 2-81

SSI/DI-S-38

GOODNIGHT, Martha M.
AN 440-32-1702
Page 2.

When a formal determination is made, you will be notified in writing by the Social Security Administration. If it is determined that you had the ability to engage in substantial gainful activity and, therefore, that your disability ceased in December, 1981, you will be eligible to receive benefits for the month in which disability ceased and for each of the two months following that month. Accordingly, the last benefit check to which you would be entitled is for the month of February 1982,

If you have any questions, please call (405) 525-3366 and ask for Ext. 247.

Very truly yours,

Thurma Fiegel MD

Thurma Fiegel, M.D.
Chief Medical Consultant
Disability Insurance Unit

TF:GMW:kg
II-P

GRENNAN, FAULKNER & KOENIG

ATTORNEYS AND COUNSELORS AT LAW

2000 CLASSEN BLVD.

SUITE 120 SOUTH

OKLAHOMA CITY, OKLAHOMA 73108

TELEPHONE 525-8606

JIM GRENNAN
M. CLYDE FAULKNER
CARL KOENIG

February 23, 1982

Thurma Fiegel, M.D.
Chief Medical Consultant
Disability Insurance Unit
Department of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125RE: Martha M. Goodnight
440-32-1702

Dear Dr. Fiegel:

Following my letter to you of January 29, 1981 in response to your letter of January 22, 1982 to Mrs. Goodnight, I reviewed and copied Mrs. Goodnight's Social Security File.

The report of Dr. Vinekar tele-recorded on November 24, 1981 recommends a total neurological and urological workup with EEG is possibly indicated at this time. The report of Dr. Buxton, Jr., tele-recorded on November 16, 1981 advises that Mrs. Goodnight is having some vestibular vertigo, possibly on a circulatory basis and headaches which probably need to be investigated. Dr. Richard Dawson's report of January 4, 1982 gives the impression of history of vertigo that is possibly consistent with Meniere's disease as well as the findings shown on the accompanying autograph and ENG. However, there is no evidence in the file that a neurological workup with EEG have been accomplished. Also, the opinion by Dr. Buxton, Jr. that Mrs. Goodnight's work capacity at this time would probably be light to sedentary appears to be contrary to other positive findings as well as his opinion that her vestibular vertigo and headaches need to be investigated. Also, Dr. Vinekar's report does not appear to indicate any opinion as to Mrs. Goodnight's ability to work or not to work at this time. Although he gives a diagnostic impression, he does not state his impression relative to Social Security's guides for impairment.

In short, I find nothing in the reports of the examination of these three examiners, named above, that support the opinions set forth in your letter of January 22, 1982 to Mrs. Goodnight.

I am presently awaiting a report from her treating physician, Dr. Wheeler, and I would appreciate your consideration of scheduling Mrs. Goodnight for a complete neurological examination with EEG as well as awaiting the report of Dr. Wheeler before forwarding Mrs. Goodnight's records to the Social Security Administration for their formal determination regarding Mrs. Goodnight's continuing entitlement to benefits.

Very truly yours,

Jim Grennan

cc: Mrs. Martha Goodnight



STATE OF OKLAHOMA
OKLAHOMA COMMISSION FOR HUMAN SERVICES

DEPARTMENT OF HUMAN SERVICES
(Department of Public Welfare)

L. E. RADER
Director of Human Services
Mailing Address: P. O. Box 25352

Sequoyah Memorial Office Building
OKLAHOMA CITY, OKLAHOMA - 73125

February 26, 1982

In Reply—Address to Director
Attention: Disability Insurance Unit

Mr. Jim Greenan
2000 Classen Blvd.
Suite 120 North
Oklahoma City, OK 73106

RE: GOODNIGHT, Martha M.
A/S: 440-32-1702

Dear Mr. Greenan:

In response to your letter of February 23, 1982. The file was reviewed again, and there is nothing in the file to indicate a definite neurological process. Social Security regulations do not allow the purchase of examinations and tests for purely diagnostic reasons, and a neurological examination with an EEG is not thought to be justified in this case.

Furthermore, there is a time limit for holding a case for additional medical. You were advised that any additional medical evidence should be in this office by February 26, 1982. Further delay in holding the case would not be of benefit to Martha M. Goodnight. The report from Dr. Wheeler can be submitted with the request for a reconsideration. This next step in the appeal process can be filed at the local Social Security Office.

If you call about this letter, call (405) 525-3366 collect and ask for extension 247. Thank you for your cooperation.

Very truly yours,

Thurma Fiegel, M.D.
Chief Medical Consultant
Disability Insurance Unit

TF:GMW:ejs
II

RICHARD B. DAWSON, M.D. & ASSOCIATES, INC.

1117 N. SHARTEL
SUITE 402
OKLAHOMA CITY, OKLA. 73101
215-4421

BOARD CERTIFIED
OTORHINOLARYNGOLOGY

PRACTICE LIMITED TO
DISEASES AND SURGERY
OF EAR, NOSE AND THROAT

FELLOW AMERICAN COLLEGE
OF SURGEONS

January 4, 1982

Floyd Moonman, M. D.
D.I.R.S.
Department of Human Services
P. O. Box 25352
Oklahoma City, Oklahoma 73125

Re: Martha Goodnight

Dear Doctor Moonman:

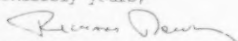
I saw Martha Goodnight on 12-30-81. Martha began to have dizziness first starting two years ago. She had a whirling sensation and then "got dark." This sensation lasted approximately two minutes and at first she would fall but now she begins to hold onto things and it is not as bad. During this period of time she gets a roaring in her ear and her hearing is said to go down. I understand in the past she has had a Medicine work up as well as a Psychiatric work up and a possible problem of hyperthyroidism was mentioned. This might explain some of the shaking she exhibits. In the past she has had a three disk laminectomy for problems of pain in her lower back and going down the left hip. This doesn't seem to be related to her unsteadiness or her dizziness. She saw Dr. Samuel Wheeler, her family Practitioner who felt that the dizziness might be on a circulatory basis. A separate problem includes headaches in the right temple area (that's where she points) and are quite severe. The nature of these headaches is thoroughly outlined in the report by Dr. Vinekar. I would certainly second his recommendation for a Neurologic evaluation and any records of this lady's thyroid treatment should be obtained and make sure we do not have a case of untreated hyperthyroidism as, of course, this can cause not only the shaking this lady exhibits but psychiatric problems as well.

Examination of her ear drums are essentially within normal limits. The nose is normal. The patient has dentures in her mouth. There are no bruits over the carotid arteries in her neck. Her finger-to-nose test is done with difficulty because of the shaking of her hands.

My impression then is a history of vertigo that is possibly consistent with Meniere's disease as well as the findings shown on the accompanying audiogram and ENG.

If I can be of any further help to you, please do not hesitate to let me know.

Sincerely yours,


Richard B. Dawson, M. D.

Key C. Rowland, Jr., Ph.D.
 Burke Chandler, M.A.
 Jen Winston, M.A.
 Sally Quillian, M.S.

LICENSED AUDIOLOGISTS

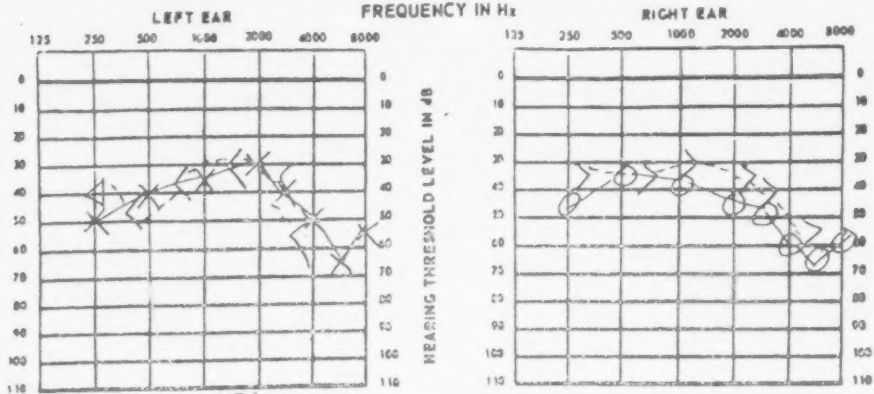
AUDIOLOGY LABORATORY

Phone 405-235-3371

1201 CLAREMONT DRIVE
 OKLAHOMA CITY, OKLAHOMA 73103

AUDIOMETRIC EVALUATION

NAME Goodnight, Martha BIRTHDATE 10/16/21 AGE 60 DATE 12-30-81
 REFERRED BY Dawson - SSI NO. EXAMINED BY Quillian



Impedance Audiometry	Left	Right
Tympanogram Type	A	A5
Static Compliance (cc)	33	20
ACOUSTIC		
Ratios	500 95	100
HTL	1000	
2000		
4000	100	95
Ballist Decay (10 Sec.)		

SYMBOLS			
AIR	MASKED AIR	BONE	MASKED BONE
L	M	B	M
R	A	>	D

TONE DECAY (1 min.)

	500	1000	2000	4000
L	0			15
R	0			15

COMMENTS:

SUMMARY			
	Left	Right	
Weber			
Bing			
Diplacusis			
Recruitment			
Loudness Balance			
Pure Tone Frequency Average	AC	BC	MASS
Speech Reception Threshold	AC	BC	MASS
Discrimination %	LV	RV	MASS
	35	35	35

Dr C. ROWLAND, JR., Ph.D.
AUDIOLOGY

AUDIOLOGY LABORATORY

1901 CLASSEN DRIVE
OKLAHOMA CITY, OKLAHOMA 73102

PHONE 405-235-3371

ELECTRONYSTAGMOGRAPHY

NAME Fordspight, Martha BIRTHDATE 10-16-21 AGE 60 DATE 12-30-81
REFERRED BY Dawson SSI NO. EXAMINED BY Quilkin

Positional Tests:

Supine: Right beats Sitting: Very mild right beats
Rt. Lateral: Right beats Rt. Lateral: possible right beats
Left Lateral: Right beats Left Lateral: possible right beats
Wh. Body L: mild right beats Wh. Body Rt: Right beats

Ocular Motor Tests:

Goze: ☒ NONE PRESENT
☐ DIRECTION FIXED
☐ DIRECTION CHANGING

Optokinetic: ☐ SYMMETRICAL ☐ ASYMMETRICAL

Eye Tracking: (1) 2 3 4

Torsion Swing Test: ☒ Asymmetrical % Failure Fixation Suppression: ☒ Positive

Differential Caloric Test:

30° C	L <u>10</u>	L (L 30° + L 44°) <u>14</u>	<u>41</u> %	} <u>18</u> %
	R <u>10.5</u>	R (R 30° + R 44°) <u>20.5</u>	<u>59</u> %	
44° C	L <u>10.5</u>	L (L 30° + L 44°) <u>14.5</u>	<u>42</u> %	} <u>16</u> %
	R <u>10</u>	R (R 30° + R 44°) <u>20</u>	<u>58</u> %	
Total:	<u>34.5</u>			

COMMENTS: Pt presents history of light-headedness, swimming sensation, blackouts, tendency to fall and lose balance, pressure in the head, soaking tinnitus bilaterally and decreased hearing in the right ear about three years, once a week in episodes of 5 minutes or less.

Endometrially she has a mild sensorineural pattern bilaterally with excellent discrimination. Tone decay is within cochlear limits and reflexes are consistent with the above.

Ocular motor tests are within normal limits.

Positional shows a spontaneous right beating nystagmus which is more pronounced in supine than in sitting positions.

Calories are fairly significant at 18% for a left unilateral weakness. Directional preponderance (right beating) is 16%.

There is potentially retrocochlear but innervation are weak.

S. Quilkin by 
Electronystagmographer

TELE-RECORDED REPORT

TAPE No. 310

☒ C/E ☐ MER

W/E GOODNIGHT, Martha M.

Called in by M. Thomas Buxton, Jr., M.D.

A/N 440-32-1702 P

1117 North Shartel, Suite 300

Date of Recording 11-16-81

Oklahoma City, Oklahoma

Date Typed 11-17-81

73103

Examination Date 11-13-81

CHIEF COMPLAINT: Back.

PRESENT ILLNESS: This sixty-year-old White lady states that in 1965, she developed pain in her lower back and pain going into her left hip and down her left leg. This was soon followed by a numb sensation over the whole lower portion of her body and some difficulty with urinating and bowel movements. She was eventually seen by Dr. S. F. Tomkins of Oklahoma City who did a three-disc laminectomy on her lower back. Since then, she has regained her sensation in her legs but she still gets tired in the left leg and, when she gets tired, the left leg drags some.

She "hasn't been the same since." At the present time, she is receiving no treatment for this condition.

SECOND COMPLAINT: Left shoulder: The left shoulder gets sore and stiff "most all the time." This is a dull ache and has been present for about six months.

THIRD COMPLAINT: Dizziness: Three years ago, she developed spells of ringing and humming in the right ear. These episodes were often followed by vertigo and, sometimes, to the extent that she fell. She saw Dr. Samuel Wheeler, a family practitioner in Oklahoma City, who said she had "difficult circulation" to the part of her head. He prescribed _____ one t.i.d. With this treatment, the spells have decreased in frequency. They last about thirty minutes. Following that, she feels weak and tremble for several hours, maybe, a couple of days. These spells occur about once or twice a month, now, and she notices they are aggravated by physical exertions such as trying to sweep the whole house at one time or turning a mattress over.

FOURTH COMPLAINT: Headaches: She has been having these headaches for about three years. They occur in the right parietal area and evidently are quite severe. They occur about every two to three months. She takes Zomax for these headaches, apparently, they help. She has not had an electroencephalogram, skull X-rays, or other neurological examination other than Dr. Wheeler.

Mrs. Goodnight was last employed as a cook at the Sky Chef at Will Rogers Field up to the time that she had her surgery in 1965. She has not worked since then. She has a tenth-grade education. She has been married forty-three years. Her husband is living and well except that he suffered retinal detachments and has now been declared legally blind. He works for the Oklahoma League for the Blind since he lost his sight in 1972.

FAMILY HISTORY: She has three children. All live away from home. Her mother

page 2

W/E	GOODNIGHT, MARTHA M.
A/N	440-32-1702 <i>P</i>

and father both died of strokes at about the age of seventy-five. There are no siblings.

PAST HISTORY: She has suffered from tonsillitis. She had a "nervous breakdown" in about 1945 when her daughter was extremely ill. This lasted ten days. Then, she recovered. She had a hysterectomy in 1957 and surgery for adhesions in 1960.

SYSTEMS REVIEW:

The eyes are corrected but she can't see at night very well, though.

She uses an herbal laxative from the Health Store for her irregular bowel movements.

She states that she is sore in her back and hands when she gets up in the morning. This lasts one or two hours.

PHYSICAL EXAMINATION:

Mrs. Goodnight is five feet three inches tall; her weight is 190½ pounds; blood pressure is 112/76.

The head is of normal contour.

In the eyes, the pupils are round, equal and react to light. The fundi appeared normal.

The ears, nose and throat also appeared normal. The drums are intact. No nystagmus is present. There is no dizziness on turning her head from side to side or lateral bending. She does get somewhat dizzy when she bends over to touch her toes and comes back up.

In the neck, the thyroid is not enlarged. No nodes are palpable.

The chest is symmetrical with adequate expansion.

The lungs are clear to percussion and auscultation.

The left heart border is within the mid-clavicular line. The rhythm is regular. There is a sternal crunch heard in the third left intercostal space and in the apical area with a Grade II murmur.

In the abdomen, the liver, kidneys and spleen are not palpable. There is no particular tenderness except in the right lower quadrant.

Pelvic and rectal examinations were not done.

The reflexes in the knees are active and equal. The right anklejerk is present. The left anklejerk is negative. Straight-leg-raising is positive on the left at about 80 degrees. She complains of discomfort in the left hip on external rotation of the hip past 45 degrees. She has a full range of motion in the right hip. Straight-leg-raising is essentially negative there although she complains when attempts are made to straighten her legs.

When squatting, she flexes her knees about 30 degrees, bends her hips forward about 130 degrees and claims that that is as far as she can go. Forward bending with

page 3

W/E

GOODNIGHT, MARTHA M.

A/N

440-32-1702 P

the knees straight is limited to within about an inch of the floor.

A surgical incision is present over the lumbar area of the back. Apparently, there is some hyperesthesia to the left of the scar over the sacroiliac joint. She complains a little bit on hyperextension of the back. Forward bending, she can do pretty well.

X-rays were made of the lumbar spine which show some osteoporosis. The joint spaces and the intervertebral spaces appear to be well preserved in all joints. The lumbosacral joint makes an almost 90-degree turn posteriorly with marked lumbar lordosis at that point.

Evidently, this lady did have multiple disc disease and had surgery. She is evidently having some back pain and left hip pain from this. She also has some generalized soreness and stiffness and there is no joint swelling, heat or erythema in any of her joints at this point. She is having some vestibular vertigo, possibly on a circulatory basis and headaches which probably need to be investigated. Her work capacity at this time would probably be light to sedentary.

Mary Filsey

8f

This transcription was made from the recording of the voice of M. Thomas Buxton, Jr., M.D.

Reporting physician

Blanks are left within this typed transcript to be filled in by the examining physician and returned after signature.

TELE-RECORDED REPORT

EJm

TAPE No. 504☒ C/E ☐ MERW/E GOODNIGHT, Martha M.Called in by SHREEKUMAR VINEKAR, M.D.A/N 440-32-1702⁰437 Pasteur Medical BuildingDate of Recording 11/24/811111 North LeeDate Typed 11/28/81Oklahoma City, Oklahoma 73101Examination Date 10-27-81

This 60 year old white married female was examined in my office on October 27, 1981, receiving psychiatric examination as authorized by the disability insurance unit. She was brought to the office by her daughter that day, who drove her to the office as the patient herself cannot drive at night, stating that she has trouble seeing at night and "everything looks weird" to her at night.

PAST MEDICAL HISTORY: Seems to be significant in that she has had arthritis in the back, has history of hyperthyroidism. She reports she has been diagnosed to have degenerative bone disease since 1966 by Dr. Cordery. She has had total hysterectomy in 1959 from Dr. Blackwood. She has had three disks removed from her lower back from Dr. Tompkins. She has had surgeries for abdominal adhesions in 1960.

She denies any alcohol or drug abuse.

In the last five years she has been coming up with headaches which are associated with pain localized in the left temporal area, rarely accompanied by nausea and vomiting. These headaches will leave her rather weak and trembling for about 4-5 days. The headaches may last 3-7 days at times and during these headaches she takes Zomax tablets every 2-6 hours, consuming about 4-5 tablets usually during the day which is known to relieve her pain. Occasionally she may pass out with or without these headaches and this passing out episodes have started only the last three years.

The headaches start in the following sequence of subjective experiences of symptoms. First she feels fullness in the head, then she starts feeling distant roaring in the head, then feels as if she is spinning. She closes her eyes and holds on tightly to some objects. This often stops the spells. If not, she will then pass out. She feels limp. She has fallen down, sustaining few bruises and definitely has not suffered any severe injuries or lacerations during any of these spells. She awakens from these with dull headaches. She states that she has been examined for this by a doctor Wheeler who has explained to her that these are because of "no oxygen to the brain", possibly referring to transient ischemic attacks. She does not recall noting any hyperventilation episodes along with these spells or during or prior to these spells and has never had any EEG studies to demonstrate whether these were indeed adult onset seizure disorder. ^{EEG} (electroencephalographic)

These spells are apparently not correlated to any stress or environmental events.

She has been placed on Ethatab, one po tid, Zomax prn for headaches and Ativan, 2 mgs. one at bedtime; all three of these given to her by her family physician, Dr. Wheeler.

She does give history of treatment for hyperthyroidism and has been diagnosed in April, 1981. Her weight in the last five years has fluctuated between 90 and 100, however, prior to her surgeries in 1965 she used to weigh 125. She has chronic trouble sleeping. She feels that she can't worry about the day, what should have, should not have and will do, etc. She does feel depressed in the last 1 1/2 years but does not have any crying spells or weeping spells. She has never seen a psychiatrist or has been treated for

Page 2

W/E GOODNIGHT, Martha M.

A/N 440-32-1702 P

depression in the past. She complains of some numbness in the left leg since her surgery in 1965 which is probably a residual radiculopathy secondary to laminectomies (or the operations on the back) with paresthesia in the left leg.

She states that she was paralyzed in 1965, between January and August when she was rather bedfast because of paralysis from waist down, at which time she had her back surgery, etc. She reports that she has been on Social Security ever since 1968. She also reports that she has a feeling that "she was mistreated during her back ailments" and gives a rather ~~coherent~~ account of the fact that she remembers all the steps during the operation as she was turned prone and was operated on her back with inadequate anesthesia and she was conscious of all the procedures all through these operations, hearing the sounds and feeling hammering, etc. She is rather bitter about this experience.

Her daily activities at the present time are mostly related to taking care of her "blind husband". She cooks breakfast, gets her husband off to work. He works as a rehab instructor at the Oklahoma League for the Blind. She makes sure that he wears the socks of the same color, etc. Then she reads the newspaper, works on the crossword puzzle, etc. She straightens up the house, may go to grocery store between 9:00 and 11:00, then gets the car off the street before 12:00 for traffic because she is afraid to drive in the traffic. She watches the 12:00 o'clock news, crochets some for grandchildren or sews. She tries to read, hangs the clothes outside, etc. Folds the clothes in the evening, gets them ready for the next day, cooks supper, etc. and tells us that her husband is transported to and fro from work by a lady and he has to pay for that. She does the dishes, watches the news again in the evening and usually gets to bed very early.

She reports that she has been allergic to barbiturates. Even now she suffers from pain in the left hip and left shoulder.

Her subjective experiences are mostly related to episodes of worry and nervousness, tremulousness but no crying spells. She worries about her husband. She worries about little things like what her husband is not able to do for himself and the fact that her husband has to be disabled, has to quit bowling, has to quit his Lion's Club activities, etc.

Her interests and hobbies are limited to reading, working in her garden which she complains is trampled by her blind husband sometimes who goes out and pulls out parsley. She helps her husband mow the lawn. Even though he is blind he has 10:00 o'clock vision in the right eye and she helps him with sweeping, etc. as he won't ask for help.

This is a 60 year old, rather thin, neatly dressed white female wearing glasses who has a rather haggard look about her. She is rather tense during the interview, very pleasant and cooperative. She reports that she grits her teeth a lot. She is coherent and has no overt thought disorder. No hallucinations or delusions elicited. She complains of mild roaring in both the ears and in her head which are probably experiences of tinnitus. She has no history of hypertension. This roaring in the ears is associated with dizzy episodes. She reports that her sleep is disturbed but it corrected by taking Ativan. Her ability to calculate is intact. Her ability to concentrate is somewhat impaired. She fears mental illness and emotional instability and is rather worried about emotional problems. Her immediate recall is within normal limits, being able to recall five out of five items at the end of 10 minutes. She presents herself as having anxiety about old age. Her insight and judgement appear to be intact.

The diagnostic impression is one of chronic anxiety and depressive neurosis which is rather moderate to severe with the Minnesota Multiphasic Personality Inventory showing elevations in the hysterical and depression scales.

She is considered competent to handle her own funds should she receive Social Security benefits.

A total neurological workup with EEG is possibly indicated at this time and she certainly has residual radiculopathy related to old laminectomy by history.

Myra Colvert
mlc

This transcription was made from the recording of the voice of Shreekumar Vinekar, M.D.

Shreekumar Vinekar
REPORTING PHYSICIAN



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A United Appeal agency

TESTIMONY OF DONNA WALTON FOR MARCH 11, 1982 SUBCOMMITTEE ON SOCIAL SECURITY HEARINGS

My name is Donna Walton and I am employed as a paralegal at the Legal Aid Society of Cincinnati. In my three and a half years of work there, I have specialized in Social Security representation and evaluated over 1500 (454 in 1981) such cases. We represent financially-eligible needy clients in their quest for disability benefits. Many times the claims are denied, necessitating appeal to the administrative hearing level. It is at the hearing that the most compelling representation is done; our win rate is approximately 80% of cases accepted. My prior experience includes working as a medical social worker at a local hospital for four years.

I'd like to speak now regarding Allied Medical, Inc., a group of doctors paid by the Social Security Administration to provide consultative examinations. My experience with this particular high volume provider has been exasperating. I will enumerate the problems I have had and give specific examples where appropriate.

1. Inconsistency of the evaluations; the materials or opinions voiced in the body of the report may vary greatly from the conclusions reached.

Example: In reviewing the file, I read a report that stated my client (a 44-year old former security guard and handyman who suffered from emphysema, marked shortness of breath, severe back pain, and hypertension) was under a severe impairment resulting from COPD (chronic obstructive pulmonary disease), yet the conclusions said he had "only a moderate obstructive lung disease."

2. Lack of adequate development of the medical evidence.

Example: Often, the evaluations are cursory and superficial, reflecting a less than fully developed examination.

3. Failure to explore all impairments or symptoms of the claimant.

Example: One of my clients suffered from arthritis, diabetes, and had a history of congestive heart failure; because the term "history of" was used in a cover letter to the consulting physician, he chose not to give much weight to the claimant's complaints of chest pain; the claimant was questioned fully regarding his arthritic complaints and diabetic complications; no EKG was given; we were a few months later able to win the case once a cardiac examination demonstrated a definite heart impairment. 20 C.F.R. parts

400-499 \$404.1526a. and \$416.926a. point out the importance of properly evaluating each impairment and considering the effect of one condition upon the other and in combination. The "total health" of the person is essential in assessing disability, as the restrictions imposed by several different medical conditions are often in combination found to be the medical equivalence to a listed impairment.

To give you an even more graphic example of how disgruntled Allied's reports tend to make people, I will tell you about one of the Administrative Law Judges in our local Office of Hearings and Appeals. Judge Musgrove reached the point where he wanted all Allied reports discredited. For that purpose he attended a hearing chaired by Senator Howard Metzenbaum so that he could testify as to how the disability terminations are severely affecting many claimants. Dr. Emily Hess, consultant to the Administrative Law Judges on disability cases, stated at that session "I have been bothered by the lack of quality of some of the physical examinations being performed by doctors hired by the Social Security Administration." A copy of the newspaper article covering the hearing is attached herein.

If you feel the above examples are at least thought-provoking, let's look at the experiences suffered by low-income disabled people. My clients have come to me with the following complaints regarding Allied. These are their words.

- I was seen by the doctor only 5-10 minutes.
- The doctor "never laid a hand on me".
- I felt like I was in a herd of cattle; we were just pushed along.
- The doctor told me there was no way I could work - but I still got turned down.
- I was made to feel like I was dirt, just something under their feet.

Imagine the stress these people must go through; first, they are threatened with the loss of income and then they have to undergo an examination that often is less than adequate. Yet the entire process is out of their control!

In my opinion, the disability terminations are aggravating the problems at Allied Medical. Their services were inadequate long before the push for cessations; but now with the greatly increased demand for their consultations, the problem has mushroomed. This, in turn, leads to more and more claimants being improperly terminated due to the lack of quality medical examinations - the type of examinations which might actually find that the disability has not ceased.

Finally, I'd like to suggest ways to improve the quality of consultative reports.

1. Provide definite standards for medical examinations; with input from a local American Medical Association office, written criteria, such as time spent in an exam, definite tests which must be given for certain impairments, etc., could be established; also there could be certain medical qualifications that must be met before a doctor could become a consultant.
2. In cases where the claimant has a treating physician, that physician should be contacted to perform the required examination and whatever tests are necessary. In Social Security's claims manual, known as POMS, section 2862D directs that whenever additional reports or tests are necessary to determine disability, the claimant's attending physician should be given first consideration. This is not being done.
3. Reimbursement for time not service.

Disabled lose out, hearing told

By Mark Roth
Special Staff Writer

A Social Security official yesterday criticizes the way his agency is cutting back on disability payments.

W. Ralph Musgrove, an administrative law judge from Cincinnati who decides on appeals of Social Security disability cases, told a hearing chaired by Sen. Howard Mennenbaum that his agency is cutting off disability payments to people who are clearly unable to work and are not getting on better.

Musgrove said he is overturning about eight of every 10 such terminations which are appealed to him, and he said the rate of such cases has tripled since the same time last year.

"I am seeing many cases now where people have degenerative diseases — arthritis, osteoporosis (bone loss), heart disease, pulmonary problems — who are being cut off the rolls even though it is clear their conditions can only get worse," Musgrove said.

The cutoffs are occurring as part of a Reagan administration push to save money on disability benefits, Musgrove said during the hearing at the Martin Joseph Living Care Center.

"Time after time people who are clearly disabled and unable to work, many of them elderly, have lost all of their income after a shoddy review and only after a lengthy appeal are those claims returned," the Ohio Democrat charged.

Dr. Emily Hess, a Cincinnati physician who serves as a consultant to the administrative law judges on disability cases, testified that "I have been bothered by the lack of quality of some of the physical examinations being performed by doctors hired by the Social Security Administration."

Examining
physician
'never laid
hand on me'

Robin Schoen



Pending system aimed, former Social Security chief says, Page 2.

Results from her doctor which showed she still has disabling heart disease and arthritis.

Mrs. Schoen said Social Security officials ended her payments on the basis of an examination done in the fall by Allied Medical in Dayton.

During the five hours she spent at Allied, Mrs. Schoen said she was seen by a physician for only 15 minutes "and he never laid a hand on me."

She concluded that technicians did perform several tests on her, but said her doctor has never been able to see the results of those tests.

Social Security officials could not be reached for comment yesterday on Mrs. Schoen's charges.

Her physician, Jack Strickler, said

he could not elaborate on her case because of doctor-patient confidentiality. But a portion of a letter he wrote which was read publicly by Musgrove said: "I would have to disagree with any determination that she (Mrs. Schoen) is not disabled."

The hearing also included testimony by Columbus resident Vera Kemp, who said she lost her disability benefits after 16 years despite letters from two doctors certifying she was unable to work because of arthritis which developed in her spine after she was run over by a car.

Cincinnati physician Hess said that Social Security officials have a right to reject a statement by a person's physician if there is persuasive clinical evidence to back it up.

But she said that recently, "many times we have had very excellent evidence from the treating physician showing a disability" and benefits have still been cut off.

Mennenbaum this week introduced legislation designed to give disability recipients more notice that their cases would be reviewed.

The bill also would require Social Security officials to consider evidence which comes from the recipient's own physician more carefully than it is now.

Much of the current problem stems from the hundreds of thousands of cases which the Reagan administration is trying to review each year, according to Robert Ball, former head of the Social Security Administration.

"They have been reviewing cases in such volume and with the instructions of 'When in doubt, take them off (the rolls), that it's clear they can't be doing a good job,'" Ball said at the hearing.



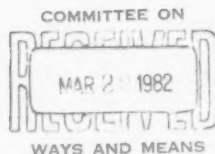
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March 17, 1982

Mr. John Salmon
House Ways & Means Committee
United States House of Representatives
1102 Longworth
House Office Building
Washington, D. C. 20515



Dear Mr. Salmon:

Re: Social Security disability consultative examinations

I have been representing claimants at Social Security disability hearings for three and one-half years. During that time I have met many interesting people who had been independent and hard working and have supported the Social Security system. These same people, as a result of an accident or illness or hard physical labor or deteriorating physical conditions eventually became unable to perform any type of work. The disability clients represented by our office have ranged in age from infancy (near-miss Sudden Infant Death) to 61 years of age. In many cases they have had a very limited education, little training and have often performed arduous unskilled labor for most of their adult working lives.

Usually in preparing my clients for their disability hearings, I question them concerning any consultative examinations that were scheduled by Disability Determination Services. One common complaint is that the consultative exams are very short and very superficial. Some clients have stated that they were not examined by the physicians who signed the medical report, but rather were examined by nurses or a physician's assistant. Clients have also complained that their examinations have lasted only five or ten minutes.

Not only are consultative examinations quick and incomplete, they often are given greater weight by the state agency than are reports from long time treating physicians. On some occasions, when consultative physicians have sent reports supporting a disability claim to the state agency, the non-examining physician reviewer for the state agency has denied the disability claim.

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Mr. John Salmon
Page 2
March 17, 1982

In December of 1978, one of my clients was sent for two consultative examinations by the state agency. Both consultative reports substantiated the claimant had severe pulmonary emphysema which was steadily growing worse and complete right bundle branch block with large and small airway disease. He was denied benefits by the state agency, but later allowed benefits at a hearing.

A 56 year old female client who was 5'8" tall, weighed 341 pounds, had a limited range of motion, was unable to perform toe heel and tandem walking, had unstable angina and insulin dependent diabetes requiring 95 units of NPH, and was diagnosed by her treating physician as a functional Class IV angina patient was denied disability benefits by a non-examining reviewing physician in the state agency even though both the consultative reports and the treating physician reports substantiated the severity of these impairments. The claimant was 50 pounds over the criteria used in determining disability due to obesity and had additional, severe impairments. The state agency evaluation dated October 12, 1979, stated the claimant had a good range of motion inspite of the fact the consultative report dated September 18, 1979 stated "she has definite limited range of motion in the lumbar sacral area". Her disability claim was allowed at a hearing.

Another client applied for Disabled Widows Benefits and her disability claim was substantiated by two treating physicians who were orthopedic specialists. The consulting physician reported the claimant was totally disabled. Again, the non-examining state agency reviewers denied the disability claim which was later allowed at a hearing. Recently a treating physician's report supporting a claim for disability benefits for a client were substantiated by the report of the consulting examiner who also felt the claimant was disabled. The non-examining state agency reviewing physician again denied this claim for disability benefits. This case has not yet been scheduled for hearing.

While I have shared several examples of consultative examinations which support a claimant's disability, the most frequent experience of those we represent, is an incomplete consultative examination. What seems to be so grossly unfair, however, is that even when the state agency's consulting physicians support a claim for disability benefits, the non-examining physicians working for the state agency, override all of the existing medical evidence and deny the disability claim. These are not unusual examples of the efforts of the state agencies not only to choose consultative examiners who will deny most disability claims, but also to ignore and reject the consulting physician reports by having their non-examining physician's deny the claims.

I feel this method of denying disability claims is unfair to those seeking benefits and is an abuse, by the state agencies, of their role in developing disability claims and is contrary to the legislative intent and purpose of the Social Security Act. Thank you for this opportunity to share this information with your committee.

Very truly yours,

Anne Hoffmaster

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AH/drv

WRITTEN STATEMENT OF
EILEEN P. SWEENEY
OF THE
NATIONAL SENIOR CITIZENS LAW CENTER
ON BEHALF OF
THE GRAY PANTHERS
BEFORE THE
SOCIAL SECURITY AND OVERSIGHT SUBCOMMITTEES
OF THE
HOUSE WAYS AND MEANS COMMITTEE
March 11, 1982

Eileen P. Sweeney
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This statement is submitted for the Gray Panthers by Eileen P. Sweeney, staff attorney, National Senior Citizens Law Center (NSCLC).

The Gray Panthers is a non-profit organization incorporated in Pennsylvania, with its headquarters in Philadelphia. It has an estimated membership of 40,000 persons who reside throughout the United States. Its members seek to reform and improve various laws and institutions which affect the lives of the elderly, including Social Security and Supplemental Security Income.

NSCLC is a national support center, specializing in the legal problems of elderly poor people. It is funded by the Legal Services Corporation and the Administration on Aging. Pursuant to the Law Center's Legal Services Corporation grant, support services are provided to legal services attorneys throughout the country with respect to the legal problems of their elderly clients. Under the Administration on Aging grant, NSCLC will be providing training and planning assistance to the states, and developing strategies to resolve the legal problems of older people without the direct delivery of services. NSCLC responsibilities include working with legal services and aging advocates on the Social Security and Supplemental Security Income problems of their clients.

We are very pleased that the subcommittees have scheduled this hearing. The claimants' experiences with volume provider consultative physicians serve to bring into focus both the problems with the consultative examination process and the need for carefully targetted, effective solutions.

The witnesses testifying today have well-documented the

problems facing claimants and beneficiaries in dealing with volume providers. Their statements certainly confirm the concerns expressed by subcommittee members at the September, 1981 hearing. Because we believe that sufficient anecdotal information has been provided, this statement is addressed to analysis of the problem and proposed solutions.

I. Relationship to the Continuing Disability Investigations

We are convinced that, over the past few years, there has been a change in tone in the disability programs. Without much written instruction, all the signals are that state disability people should cut the rolls and keep them small. This has resulted in the termination of severely disabled individuals as well as the denial of new applicants. These signals include:

- requirements that SSA review allowances but not denials or terminations;
- excessive emphasis on speed to the exclusion of accuracy;
- as a corollary, the failure to require states to assure that there be adequate evidence development;
- public discounting by SSA of the currently high ALJ reversal rates, arguing that it is the ALJs who are out of step with SSA and ignoring the growing problems at the state level;
- statements indicating that SSA is affecting budgetary savings in the disability program by terminating high percentages of allegedly non-disabled persons.

In effect, the Administration is making the budgetary savings

in the disability programs by cutting eligible people; exactly what Congress refused to allow them to do last year.

Often, the only documents supporting these arbitrary and incorrect decisions are the inadequate reports of consultative examiners. In many states, the volume or bulk providers are churning out report after report, denying disabled individuals the benefits to which they are entitled. In Tennessee, for example, the volume provider denies disability at a higher rate than the average. (82.5% compared with 73%.)*

All indications are that SSA is concerned with speed, not accuracy, in the disability determination process. That message has been made very clearly in the SSA regulations governing the federal-state relationship. Given the emphasis on time and the incredible backlog created by the CDIs (as well as the acceleration of the CDI process),** it is not at all surprising that the states place a premium upon a physician's ability to provide reports in the shortest time possible. Two aspects of this are particularly disturbing. First, time appears to take priority over all, or almost all, other relevant considerations in making the referrals to consultative physicians.~~Second, the volume providers, doing all or almost all of their business with state DDS units, recognize

*At the September 18, 1981 hearings, Herbert L. Brown, Director, Disability Determination Section, Tennessee, stated that, in a sample review, Thurman and Thurman denied 82.5% while the state average was 73%. "Volume Providers of Medical Examinations for Social Security Disability Programs," Serial 97-27, page 92.

**For example, Mr. Brown testified that "[t]hose cases have been stacked up in boxes in the corner of our office for several weeks." Id., page 87.

this need and, with their word processing equipment and often questionable practices, are able to capitalize upon it, to the detriment of disabled individuals.

The states' preoccupation with timeliness is reflected in the material which SSA has provided to the subcommittees, set forth at Serial 97-27, pages 25-34. Timeliness of reporting is often cited as a basis for identifying a referral while no reference is made to identifying the physician(s) whose specialty renders him/her in the best position to properly assess the claimant's condition.

While it is important that the states operate efficiently and assure that decisions are made in timely fashion, steps should be taken to assure that accuracy is not sacrificed in order to meet this need, we propose that SSA be required to amend its regulations to shift the emphasis to assuring accuracy in decision-making at the state level.

To reinforce this shift, SSA should be required to review disallowances in the same fashion that they currently perform pre-effectuation review of allowances. It is not adequate to argue that the ability to appeal the denials is a self-policing mechanism rendering review of disallowances unnecessary. If that was true, SSA would currently be questioning the state's abysmal records rather than attacking the ALJs' high reversal rates. SSA simply does not view ALJ reversals as any reflection upon the accuracy of state agency decision-making. The result is that the easiest, least monitored, route for the states to take is to deny, regardless of the severity of the person's impairments.

II. The Need for Legislation

The federal government paid approximately \$137,400,000 for consultative examinations in 1981.* That figure will increase if the Part B rates proposed in H.R. 5700 are utilized. It is therefore reasonable to assume that SSA should be expecting to get something useful for its money.

In some areas of the country, the administrative law judges simply ignore the consultative reports because their experience with the particular provider(s) has taught them that their reports are useless and unreliable. Given the current abuses of some consultative physicians, this is as it should be. However, it is critical that the cost implications be recognized. Because SSA has failed regulate consultative physicians, it is throwing money away just so that it can assure that there is a piece of paper in the file. If the reports are so useless as to be ignored, they should not be purchased. It is critical that SSA be required to issue regulations which set forth minimum requirements for consultative physicians. The factors set forth by Martin Wegbreit in his testimony today are appropriate areas for regulation:

- 1) a limit on the number of examinations which may be scheduled per hour and per day;
- 2) minimum competency requirements for technicians, aides and paramedics who assist in performing the exams;

*Statement of Sandy Crank, Associate Commissioner for Operational Policy and Procedures, Social Security Administration, September 18, 1981 hearing. Serial 97-27, page 12.

- 3) periodic checks on the equipment used in consultative exams;
- 4) a requirement that the consultative physician personally author and sign the report and the physical capacities evaluation;
- 5) a requirement that the state unit consider paying for a consultative exam performed by the claimant's treating physician before considering a referral to a non-treating physician;
- 6) a requirement that the State Disability Determination Unit establish contacts with community health clinics to assure that more consultative exams are performed locally instead of by volume providers;
- 7) require written documentation as to how much time the consultative physician spent examining the claimant;
- 8) require written documentation that the laboratory tests and x-rays were actually done.

In addition, (9) the consultative physician should be required to have familiarized himself/herself with the various test results and to have personally read all x-rays prior to completion of the report. While it is common medical practice for hospitals and clinics to have all x-rays read by a radiologist, it is difficult to believe that any specialist who had ordered x-rays would enter a final diagnosis without first personally reviewing the x-rays.*

*Yet, this subcommittee has been informed of x-rays being read hundreds of miles away from the site of the examination by a person other than the examiner with the x-ray report only being included when the material is put into the form of a final report. This reference is to the operations of Dr. Lipman.

(10) The regulations should also establish some mechanism for assuring that claimant complaints regarding consultative physicians are investigated and resolved.

Two provisions of H.R. 5700 do address a portion of the problem, but nothing in the bill attempts to solve any of the problems previously mentioned. While H.R. 5700 is helpful, it does not address the failure of SSA and the states to properly regulate and monitor consultative physicians.

Section 16 of H.R. 5700 provides that the fees for consultative examinations will be set at 100% of the prevailing charge under Medicare Part B. This is a reasonable response to the concerns of state disability personnel that the fees, now determined by each state, are often too low to attract physicians other than the volume providers.

The provision would also require that SSA contract with one carrier to pay all consultative examination fees. As long as the carrier acts "efficiently and effectively," as required in H.R. 5700, utilization of one carrier should permit SSA to easily identify the volume providers and, possibly, abuses. However, if the carrier delays in reimbursing physicians it is likely that, regardless of the increased fees, non-volume provider physicians will continue to avoid these cases.

The bill should provide some mechanism for withholding payments where a state or SSA determines that the work requested was not provided.

Conclusion

An already bad volume provider situation is being aggravated by the fervor with which the Administration is terminating eligible disabled people from the rolls. Steps must be taken to reverse this pattern, to change the tone of the process. This can be accomplished at least in part by requiring SSA to review disallowances and by rewarding accuracy in decision-making. In addition, the specific steps proposed here should be taken to assure that SSA and the states properly regulate and monitor the work of consultative physicians. Elimination of the abuses will help to assure that claimants are treated fairly and that the government receives something of value for its money.

Thank you for considering these comments.

Respectfully submitted,

Eileen P. Sweeney

Eileen P. Sweeney
National Senior Citizens Law Center

March 11, 1982

TESTIMONY OF NEIL E. ONERHEIM

Before the Subcommittees on Social Security
and Oversight, House Ways and Means Committee
March 11, 1982

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As an attorney representing Social Security Disability claimants in Lawrence, Massachusetts for the last five years, I am familiar with the work of a Massachusetts volume provider of medical examinations, Northeastern Medical Associates. During this time, I have represented approximately 100 claimants and have supervised paralegal representation of at least 200 additional claimants.

Over the last five years the Massachusetts state agency for disability determination has purchased the vast majority of its internal medicine consultations in the Lawrence area from Northeastern Medical Associates and its two internists, Michael Pisick and Marion Wind. I have had an opportunity to review well over 200 reports prepared by these physicians following their examination of my clients, and to compare these reports with medical evidence from other physicians who have examined these clients.

I wish to provide you with some specific examples of problems I have found with this volume provider, and also to draw some general conclusions about the unreliability of this provider's reports. Finally, I wish to suggest some action to address these problems.

Drs. Pisick and Wind conduct exercise tolerance tests on claimants with heart conditions. In this test, the claimant's heart is monitored during exercise. In order for the test results to have any diagnostic significance, the patient's heart rate must be elevated to 85% of his or her maximum predicted heart rate. I have reviewed several of Dr. Pisick's reports of exercise tolerance tests where

the patients' heart rates were only 50% of the predicted maximum, yet Dr. Pisick concluded that the tests showed no evidence of abnormalities. I consider such medically unsupportable practices to be among the most pernicious form of deception a physician can engage in, because they allow meaningless information, which is technical and indecipherable to the lay person, to masquerade as legitimate diagnostic evidence of the ability to work.

Social Security regulations acknowledge that the exercise tolerance test should not be performed on certain patients who could be harmed by the exercise which is required. One of my clients who was to be examined by Dr. Pisick was instructed by her personal physician not to take this test, and her physician gave her a letter explaining why the test was contraindicated. The claimant gave Dr. Pisick this letter and other supporting medical records. Dr. Pisick insisted that my client take the test, and told her that if she refused he would deny her disability benefits on the spot. Under this threat my client began the test. Dr. Pisick was not present during the administration of the test. My client complained of chest pain during the test but two nurses told her to continue the test. Soon thereafter, she collapsed and Dr. Pisick was informed of the problem. Dr. Pisick took no action to see my client or to assist her. My client's neighbor drove her to the emergency room of a local hospital, where she was transferred by ambulance for treatment in a Boston hospital. She considers herself lucky to be alive.

Another of my clients injured his right thumb in an accident in 1972, and in that year his right thumb was amputated just beyond the metacarpal-phalangeal joint, practically at the joint. For all practical purposes, this man has no right thumb. Dr. Pisick evaluated this man in March 1977, and his report states that there is no cyanosis or clubbing of the extremities, that examination of the hands showed a full range of motion, that digital dexterity was normal and that the claimant was able to make a fist without difficulty. Dr. Pisick, who stated that he conducted a "careful thorough" examination of the claimant, failed to note that

this claimant was missing a thumb.

Last month I reviewed four reports prepared over a four year period by Drs. Pisick and Wind concerning another claimant. In February 1977 Dr. Pisick found that this woman was 62 inches tall. In November 1978 he measured her at 63 inches. In December 1980 Dr. Wind said that the claimant was 64 inches tall, and in April 1981 Dr. Wind measured her at 61 inches. In four separate examinations, Drs. Wind and Pisick were unable to make the same finding twice on such a simple matter as the claimant's height.

Height is an important determinant of the significance of pulmonary function test results, where taller persons are expected to perform better. This claimant suffers from a severe respiratory impairment, and is thoroughly winded after walking as little as thirty feet. The pulmonary function test results for this client place her at the borderline of a severe impairment if her height is 64 inches, but demonstrate conclusively that she is disabled if her height is anything less. You can appreciate my skepticism at Dr. Wind's impartiality when you understand that she measured my client at 64 inches the day the pulmonary function tests were done and at 61 inches four months later, when the pulmonary function tests were not run.

Drs. Pisick and Wind are not Board certified in psychiatry, yet they regularly comment on a claimant's mental status on the basis of contact during a ten minute physical examination. I have seen claimants with severe mental impairments who are denied benefits by the state agency on the basis of these physicians' unsupported comments on mental status. Dr. Pisick conducted a physical examination of one of my clients with a severe personality disorder and a long history of depression. During the examination my client got in a heated argument with him and ran out of the room. Dr. Pisick's report does not mention this incident, and states that my client "related appropriately."

I have seen many other examples of erroneous and internally inconsistent reports

from these physicians. Most claimants tell me that they spend from five to fifteen minutes with the physician. Drs. Pisick and Wind use a standard form report for a healthy person, which recites a litany of normal findings. While this information is interesting, it is of relatively minor significance in evaluating the claimant's impairments, which are treated very cursorily. The consulting physician should put most of his or her time and energy into a thorough evaluation of what is wrong with the claimant, so that the state agency can make an informed decision on the effect of these impairments on the claimant's ability to work. Presumably because it is not profitable to do so, these physicians routinely fail to perform more than the most superficial evaluation. They often acknowledge that their findings are based solely on historical information related by the claimant without supplying the supporting medical evidence which Social Security requires. Without detailed evaluation of the claimant's impairments, these reports are a waste of taxpayers' money. More importantly, from the claimant's perspective, the reports fail to document severe impairments well enough for a finding of disability. Several Administrative Law Judges who have heard what should have been unnecessary appeals from denials based on the Pisick-Wind reports have excluded these reports from the record or informed me that they attach little weight to reports from these physicians. These appeals impose needless suffering on claimants and needless expense on the Social Security Administration.

I have encountered a significant number of clients who were sent to Dr. Pisick but reported that they had seen only women. Dr. Pisick has signed reports for these claimants, stating that he has examined them and commenting on their medical condition. Investigation has revealed that these claimants had been seen by Dr. Wind, who is Dr. Pisick's wife and partner, and that Dr. Pisick had signed the reports without ever seeing the claimants involved.

As these examples make clear, the use of volume providers invites abuse.

I believe that this evidence supports the two conclusions which I have been forced to draw: first, that the volume provider conducts only cursory examinations and reports largely irrelevant information in an attempt to complete as many evaluations as possible and thus make the operation profitable; and second, that the volume provider, who understands that the state agency is under pressure to limit findings of disability, is less likely to conduct a thorough evaluation of impairments and to bias his or her report against a conclusion of disability in order to encourage the state agency to continue to purchase its reports from that provider. This is especially true for physicians such as Drs. Pisick and Wind, who to my knowledge do not practice medicine beyond these consultations with the Massachusetts state agency.

Case law and the Social Security Administration's policies acknowledge that the opinion of the claimant's treating physician is entitled to the greatest weight in the evaluation of disability. I believe that when the state agency wishes to purchase additional medical evidence in order to make a decision, it should be required first to purchase this information from the treating physician. While the Social Security Administration's Program Operations Manual System, §DI2862.D appears to require the state agency to give first consideration to purchasing the report from the treating physician, this provision is widely ignored in practice. In fact, I have only seen this done in one case in five years, where the treating psychiatrist happened to have a regular contract with the state agency.

Although the state agency usually attempts to contact the treating physician, the fee paid for this report is negligible or nonexistent. I hear physicians and their staffs complain on a daily basis about the massive volume of uncompensated paperwork they are required to complete for private, state and federal disability programs. It has been my experience that many claimants are erroneously denied benefits because their physicians submitted incomplete reports.

If the funds used to purchase evaluations from volume providers were instead directed to treating physicians with specific instructions as to the type of information required, I believe that most treating physicians would provide far more reliable reports than are currently obtained from volume providers. I have also found that treating physicians are not reluctant to identify claimants whom they consider to be malingerers.

While the mechanism for this policy of purchasing reports from treating physicians exists now, I believe that this policy will not be implemented in practice unless Congress acts to require the purchase of medical information for a reasonable fee from the treating physician.

I believe that the volume providers should be eliminated. Instead, when a treating physician is unavailable or refuses to provide a report for a reasonable fee, the state agency should be required to develop a more extensive list of consultants. I have not encountered the type of problems I have mentioned with the many consultants who perform more limited numbers of evaluations as part of their medical practices. There should be a limit on the percentage of time which a physician can spend as a state agency consultant. The full-time consultant is neither a reliable nor an impartial informant.

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